HEALTH ASSESSMENT OF THE ELDERLY

AT HOME

BY

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ABSTRACT OF THESIS (Regulation 7.9)

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There is evidence of a continuing reservoir of unmet health needs in elderly people in the community. In spite of widespread recognition of this problem, schemes to detect and deal with these health needs have not been implemented on a wide scale. At the outset of the research, the lack of an agreed system for detecting health problems was seen as a major impediment to the implementation of effective anticipatory care for older people. The initial aim of the research therefore was to develop a validated case finding package for use by health visitors and others in primary care. However, a review of the relevant literature raised doubts about the value of a standard case finding package and about whether such an approach to health assessment of older people would be welcomed by primary health care teams.

These doubts were reinforced by three exploratory studies: interviews with health visitors experienced in the use of protocols of assessment, video-recordings of health assessment interviews with older people, and showing an excerpt of one of the video-recorded interviews to a group of health visitor students. Together the review of the literature and the exploratory studies revealed that major uncertainties exist about the purpose, content and benefits of health assessment of older people and about the views and feelings of health professionals to this activity. The studies described in the thesis therefore sought to:

1. Describe the scope and content of health assessments of older people at home as perceived by different professional groups and by older people themselves.
2. Provide information on the views and feelings of different professional groups towards visiting and assessing the health of older people at home.
3. Describe how different health professions perceived their own role and the role of others in assessing and responding to the health needs of older people at home.

In the exploratory studies, the use of an excerpt from a video-recorded interview with an older person had been found to be a potent method of eliciting the views and feelings of health visitor students and this method was also used in the main study which involved 11 professional groups and two groups of older people. A total of 276 health professionals and 31 older people participated in the study.

Although individual health workers lacked a clear framework, collectively there was considerable consensus concerning the scope and content of health assessments of older people. This collective framework closely agreed with the views put forward by older people themselves. Within the overall framework, different professions had different prospectives and different areas of strength and weakness. The views and feelings of health professionals towards working with older people were found to be basically positive, but participants expressed reservations about the effectiveness of their work with older people. The students expressed more positive feelings than the experienced health workers.

The thesis concludes by making recommendations aimed to improve the health care of older people. These recommendations concern the education of health workers, the management of health services and the direction of future research in this area of health care.

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'HEALTH ASSESSMENT OF THE ELDERLY AT HOME'

PREFACE

Two connected influences on me as a medical student led to the studies and ideas contained in this thesis. The paper by Williamson and his colleagues (1964) which described the unmet health needs of older people at home was the first influence and caused me to look at the health of older people registered at one large city practice and at their contacts with the health services during an undergraduate elective period in general practice (RCPE 1970). My elective project in 1969 involved identifying elderly people on the list of the practice from an age/sex register, selecting a stratified 1 in 10 sample of them, recording the contacts of this group with the practice during the previous year, and visiting them at home in an attempt to ascertain their health problems.

My interpretation of the results of the study were:

1. Older people living in their own homes were in frequent contact with the health services (all the people aged 75 or over and those who lived alone had been seen by a general practitioner in the nine months preceding the study).
2. These patient-initiated contacts were insufficient to reveal the whole range of existing health problems in this group (for example, urinary incontinence, memory impairment and foot problems were infrequently recorded in the medical notes).
3. The doctors and health visitors in the practice appeared uncertain how to meet the health needs of the increasing numbers of older people (although both doctors and health visitors routinely visited a number of housebound elderly people, there was no agreed plan about which patients should be visited or the purpose of the visits).
4. There were weaknesses in communication between different members of the primary care team (information about patients kept in different record systems resulting in both duplication and gaps).

This student project indicated to me that the health care of older

people in the community was one of the most important challenges facing the National Health Service. It stimulated me to select geriatric medicine as one component in a vocational training scheme for general practice and subsequently influenced me in applying for, and being appointed in 1974 to a conjoint post as a general practitioner in Livingston New Town and hospital practitioner in the department of geriatric medicine in the local district general hospital, Bangour. The Livingston experiment in health care was established in 1966 (SHHD 1982), with the aim of integrating primary and secondary care. I was attracted by the potential provided by the post for developing community health services for older people, using the resources both of general practice and of the hospital.

My first few years in practice and in hospital reinforced my view that a reliance on patient-initiated contacts and unstructured consultations resulted in many health problems remaining undetected. In 1976, in order to test this view, and in collaboration with an interested health visitor, I constructed a simple protocol for assessing the health needs of older people in the New Town. This protocol was based on the assessment schedule developed by Barber and Wallis (1976). Livingston had, and still has, an unusual population distribution with at that time only 5% of the population over the age of 65 years and 1% over 75 years. Despite the low number of older people in the community, it took considerable effort to persuade and encourage health visitors in three different centres to carry out the survey. The results of the survey indicated that most of the elderly residents in the New Town were in good physical health but many felt unhappy and isolated. Some of the older people felt lonely even when they were living in the same house as their children. At that stage in the development of the New Town almost all the old people had recently moved there. Difficulty in adapting to an unfamiliar environment was a possible reason for the high prevalence of expressed feelings of unhappiness and loneliness.

I was disappointed to find that the initial enthusiasm created by this

survey for seeking out health problems in the elderly soon evaporated. Although one or two health visitors and general practitioners continued to visit older people in a planned and systematic fashion, most of the health visitors reverted to seeing older people only on referral and devoted the major portion of their time and effort to visiting families with pre-school children. This survey indicated to me that systematic surveillance of the elderly could be achieved but that it required careful planning and the active co-operation of different health professions to sustain it.

The survey caused me to question the assumed benefits of seeking out unmet health needs in the elderly and also question the validity of assessments which are carried out by different health personnel. Some of the health visitors felt that it was unhelpful to identify problems such as urinary incontinence for which condition they felt little could effectively be done, or foot problems where inadequate chiropody services meant that expectations of treatment might be unrealistically raised.

An unexpected adverse effect of the survey was that some of the elderly people had been falsely reassured by their assessment and consequently failed to report ailments at an early stage. This problem was possibly due to the particular method of assessment used in the survey but did contribute to my questioning of the value of providing health care to elderly people by means of doctor-initiated contacts as a form of anticipatory care.

I was surprised to find that few studies in the United Kingdom (Williams 1974 and Lowther et al 1970) had tried to evaluate the benefits of anticipatory care in the elderly. A search of the literature in 1975 did not reveal any studies which had compared experimental groups with control groups. Because of the lack of a strong scientific basis to justify anticipatory care for older people in the community, I thought that it was possible that the scattered schemes and initiatives in anticipatory care would soon falter and general practice would continue to rely on a contingency type of medicine in relation to the elderly

characterized by patient-initiated consultations for the majority and routine regular visits to a small minority of elderly patients who were known to have medical problems.

During 1978 and 1979 I tried to set up a study into the possible benefits of anticipatory care for older people in the community. My intention was to provide health assessments for half the total sample of patients aged 75 or over in six general practices and compare the outcome over a two year period with the other half of the sample for whom no structured or systematic approach to assessing their health needs would be adopted but who would have similar levels of resources available to them. I could see that there would be difficulties in ensuring that the control group would not be influenced by the health assessments provided for the experimental group of patients. The control group of patients would possibly receive more attention from doctors, health visitors and nurses than usual because of the general stimulation of interest in the elderly generated by the study. Because of these and perhaps other weaknesses in the design of the study, applications for funds were rejected. Tulloch and Moore (1979) were successful in evaluating the effect of health assessments in the elderly using a control group. In addition to the above weaknesses in this approach to evaluation, their study was based on a single general practice and the assessments carried out were not tested for validity or reliability.

By 1980, the criticisms of my research application and my own criticisms of the study by Tulloch and Moore led to a change in my area of interest for research. I felt that before an attempt could be made to evaluate the benefits of case finding in the elderly, it was necessary to do two things:

1. Construct, after examining existing assessment methods, a schedule of health assessment capable of implementation as part of the routine work of health visitors and other health personnel.
2. Assess whether this schedule was valid and reliable in assessing the health needs of older people.

In 1981 Help the Aged agreed to support the funding of a project which intended to carry out these two objectives.

As a first step I looked at the way in which a health visitor and a general practitioner carried out health assessment of older people at home. Video recordings of their interviews with housebound elderly women were made. Excerpts of the recordings were shown to a group of health visitor students on the last day of their training course. Health visitors, district nurses and general practitioners who had been involved in screening and case finding projects in different parts of Scotland were interviewed. A search was made of the literature on screening and case finding in the elderly and about the role of health visitors in this work. This literature will be reviewed later.

From these exploratory studies different themes emerged:

1. Each assessment interview was unique. Not only did the health needs of older people differ widely but the way in which the interviewed housebound older women responded to question caused assessments to proceed along very different routes. Attempts to conduct assessments in a predetermined manner were resisted and thwarted by the women interviewed.

2. Health visitors, district nurses and doctors adapted and modified protocols designed for health assessments to suit their own needs and became selective in the people they considered suitable for using such an approach.

3. Interviews with health visitors and the discussion with health visitor students revealed their disappointment about the lack of a usable theoretical framework for their work with older people. Without a coherent concept of normal ageing, health visitors found it difficult to identify a clear purpose for their visits to older people. This vagueness about the purpose, and consequently the content of assessment visits, was put forward as being a barrier to health visitors devoting more time to visiting the elderly.

4. Many different professions were involved in assessing the needs

of older people at home with considerable overlap in the roles of doctors, district nurses, health visitors, social workers and home care organisers. In addition, other professional groups such as physiotherapists and occupational therapists were also carrying out health assessments of older people at home.

5. Communication and co-ordination between different members of the primary health team in caring for older people was felt by team members to be inefficient. There appeared to be false expectations by one professional group about the scope and priorities of work of other groups.

These exploratory studies caused the direction of my research interest to change in a radical way. I abandoned my attempt to be prescriptive in introducing, testing and measuring compliance in implementing a specific protocol for health assessment of older people. I felt that there were so many uncertainties in the minds of health personnel about the nature and purpose of health assessments of older people that it would not be possible to develop an agreed approach to case finding until shared concepts about this aspect of health care could be identified and described.

I wished to learn from: the collective experience of health visitors, general practitioners and other professional groups; from the perceptions of learners in these professions; and from the views of older people themselves about the scope, content and structure of health assessments and how the different professional groups involved feel about their work with older people.

This thesis considers these views, perceptions and feelings. Part I considers in more detail the issues touched upon in this preface and describes the exploratory studies (pages 28-33) which helped to clarify the aims and objectives of the studies described in Part II. In Part III I attempt to interpret the results of these studies and make recommendations based on the evidence in Part II for changes in the ways in which the health care of older people in the community should be provided in future.

PART I

PART I

REVIEW OF LITERATURE

UNMET NEEDS

The existence of unmet health needs in older people living at home is the starting point for this thesis. Numerous studies over the past three decades in the United Kingdom have revealed the extent of unmet health needs in elderly people living at home (Williamson et al 1964, Thomas 1968, Burns 1969, Milne et al 1972, Hiscock et al 1973, Currie et al 1974, Gardiner 1975, Barber and Wallis 1976, Hunt 1978, Ebrahim et al 1987). The picture is not a uniform one. A few studies have not demonstrated significant unmet health needs in the elderly but these studies considered well favoured groups of older people, for example, older people in prosperous suburban or rural parts of the country (Evans 1970, Irwin 1971, Freedman et al 1978).

It is possible that there has been a secular change in the health status of older people in the community. The pioneering studies in Scotland (Anderson and Cowan 1955, Williamson et al 1964) revealed high levels of unreported illness in older people living at home. By the mid and late 1970's studies into the health needs of older people focussed on the detection of disabilities rather than illnesses (Williams 1975, Freedman et al 1978, Tulloch and Moore 1979). It is not established whether this difference is because of a change in the views of doctors and health visitors about what is important to look for or whether it is due to a change in the prevalence of unreported and/or unrecorded illnesses affecting older people in the community. This change in approach in assessment is discussed later in the section in 'Screening and case finding'. (p.11)

The earlier studies referred to above assumed that elderly patients either failed to report illnesses and disabilities to their general practitioner or were selective in how they did so. It was found both in the United Kingdom (Williamson 1981) and in North America (Brody and Kleban 1981) that problems relating to the cardiovascular system, the

respiratory tract and the central nervous system were well known to the elderly person's family doctor but that common distressing problems with bladder and bowel function, disabilities associated with painful joints and feet, and impaired mental functioning due to dementia and depression were not.

However, Hannay (1979) has shown that older people are less likely to neglect illnesses than younger adults and Ford and Taylor (1985) have suggested that older people do not under-consult, and Ebrahim et al (1984) in their study of older people who do not consult found that this small group are a health elite with few health problems. Thus, the problem may not necessarily be the under-reporting of health problems by older people but may be the under-recording and possibly the under-recognition of health problems by doctors, health visitors and nurses.

In order to understand why this may be so, I looked at studies which describe the pattern of contact between older people and the health services.

PATTERNS OF HEALTH CARE FOR THE ELDERLY

GENERAL PRACTITIONERS

My student project (RCPE 1970) indicated that in one general practice disabilities remained unknown to the primary health care team in spite of frequent contact between older people and the health services. Larger surveys confirm the high consultation rate for older people with their general practitioner (OPCS 1974 and 1986), 75% of patients over the age of 75 are seen by their general practitioner each year and 33% of patients over the age of 65 are in contact with their general practitioner each month.

These observations emphasise the point that under-consulting is not the cause of the under-recognition of health problems affecting older people in the community. Patient-initiated consultations with general practitioners would appear, in general, <u>not</u> to lead to the recording

of all the health problems experienced by older people.

There are a number of possible reasons for this. The tendency for older patients to have multiple health problems may cause both the doctor and the patient to be selective in focussing attention on the apparently most urgent problem. Although the average length of consultations for older people is no longer than those for younger age groups, it is still less than 10 minutes (Wilkin & Williams 1986). Both doctor and patient may feel that there is insufficient time to discuss anything in addition to the presenting problem. Even if additional time could be made available, it is not certain that this would necessarily lead to greater awareness on the part of the doctor about the health needs of their elderly patients. A small list size and consequently a doctor possibly having more time available per patient has not been found to be associated with a higher level of investigation or referral of elderly patients (Wilkin & Metcalfe 1984, Wilkin & Williams 1986).

Perhaps the lack of a simple structure for health assessment inhibits general practitioners from expanding their questioning of patients beyond features of direct relevance to the present problem. Freer (1987) suggests making better use of patient-initiated contacts by the general practitioner running through a simple check list of assessment categories during the consultation. The idea of building upon the existing high level of contact between older people and general practitioners is an attractive one but he does not present evidence to show that this proposal is feasible or would be effective.

HEALTH VISITORS

Contact with older people constitutes a small percentage of most health visitors' total workload (Clark 1981). In spite of recommendations by bodies such as Age Concern (1978 & 1986) and official reports (SHHD 1980, DHSS 1981) there has been no evidence of a general increase in the time spent with older people by health visitors and recent government statistics show that only 13% of clients visited by health visitors are 65 years or older (CSO 1985).

On an experimental basis, a few health visitors have been appointed specifically to work with older people but in many areas health visitors are not encouraged to give the elderly a high priority in their case load (Fitton 1983).

A prominent feature in the patterns of work of health visitors is the wide range in the percentage of their total visits which they make to older people (Clark 1981). This wide variation is not related to the number of potential elderly clients nor to the total workload of health visitors (Luker 1987) and the variation exists within health authority boundaries. The variation, therefore, must reflect the individual health visitor's personal priorities and preferences in her work.

DISTRICT NURSES

District nurses spend most of their working day with older people but in the main do so in a reactive way, responding to requests by patients, general practitioners or hospital staff to provide specific nursing services. Even so, district nurses only see the very small proportion of the elderly at home who are either very frail or need skilled nursing care for problems such as varicose ulcers or stoma care (Jones et al 1983). Changes in the training of community nurses (CETHV et al 1983, Project 2000 1986 and Cumberlege Report 1986) is blurring the traditional distinction between the roles of health visitors and district nurses. In future, district nurses may be involved in seeking out health needs in the elderly as well as providing direct nursing care. This will have considerable implications in the already complex area of teamwork in primary health care.

In this section I have described the patterns of contact between older people and the primary health care team. In spite of frequent contact between older people and general practitioners, a reservoir of unknown or unrecorded health problems continue to exist. As a result there have been calls for systems of planned systematic health assessments of older people to be implemented (Age Concern 1977 and 1986, Arie 1981).

A search for schemes of anticipatory care in the United Kingdom in 1986 revealed 30 such schemes (Taylor and Buckley 1987). It is likely that more schemes do exist but it does not appear that anticipatory care has been implemented on a wide scale.

SCREENING AND CASE FINDING

There has been confusion about the terms which should be properly employed to describe the systematic and planned detection of established disabilities and health problems. Williamson (1981) suggested that case finding should be the preferred term for such activity.

In this thesis, I use the term screening to describe a systematic approach to the detection of disease previously unrecognised by the patient and case finding to describe activities by health professionals in seeking out health problems known to the patient but not previously recorded. The distinction is important because the criteria which should be used to evaluate the two activities are different.

Wilson (1966) put forward ten criteria which need to be met before a screening programme can be justified. The requirements for a case finding programme are less stringent in that intervention for established disability can be considered to be a form of treatment rather than prevention. Nevertheless, drawing attention to an established disability may be detrimental to the independence of an elderly person if not done in a sensitive manner, particularly if practical help cannot be recommended or provided.

Screening for asymptomatic disease in older people is superficially attractive in that biochemical and haematological tests give a relatively high yield of apparently abnormal results. However, most of these abnormalities are mild and may indicate that the normal range for the laboratory has been calculated from the figures for younger

age groups rather than indicating a true disease process. In a large study in England (South East London Screening Study Group 1977), multiple biochemical tests for pre-symptomatic disease in middle aged men failed to produce a significant difference in subsequent health between the study group and a control group. Similarly, Murray and Young (1977) failed to demonstrate a correlation between abnormalities on multiple biochemical and haematological tests and subsequent cause of death in a group of older people.

The shift in emphasis in anticipatory health care of older people from screening to case finding has been a gradual one. The failure of biochemical and haematological screening tests to alter subsequent morbidity and mortality is one factor in this change but there also appears to have been a change in the way in which health in general is perceived and this influences the perception of health needs of older people. The World Health Organisation definition of health (1980) is not the absence of disease but is the dynamic concept of an individual functioning at an optimum level.

Perhaps, in tune with this general change in the perception of health, changes have taken place in the expressed aims of screening and case finding in the elderly. Following the earlier work in Scotland (Anderson and Cowan 1955, Williamson et al 1964) which had concentrated on the detection of disease and their precursor states, Williams (1975) suggested that the main purpose of case finding was to improve the functional capabilities of older people. Similarly, the aim of health promotion for older people by health visitors has been considered to be improving the quality of life rather than increasing life expectancy (Luker 1981, Robertson 1984). Minimising symptoms and assisting older people to carry out their desired range of activities have been put forward by Freer (1985) as the main aims of health care in this age group. If these views are generally accepted, the evaluation of health care should include estimates of the functional abilities of older people and include their own perception of their health.
This change in concept about the purpose of health assessments and

anticipatory care for older people in the community has not been widely appreciated. As a consequence, the criteria which should be used to assess the validity and effectiveness of different approaches to anticipatory care have not been established. This will become evident in the next two sections where I discuss the few studies which have considered the validity of health assessments and studies which have attempted to assess the benefits of case finding programmes.

VALIDITY OF HEALTH ASSESSMENTS OF OLDER PEOPLE

In the United Kingdom, health visitors, district nurses and general practitioners have been the main professional groups involved in surveys of health needs of older people at home (Ness and Reekie 1970, Powell and Crombie 1974, Heath and Fitton 1975, Wallace 1975, Barber et al 1980, Gooding et al 1982). The surveys used different schedules, questionnaires and protocols, whose validity has not been tested. In the United States of America, standardised assessments of the functional capabilities of older people have been developed for use by lay personnel (OARS 1978, MAI 1982, CARE 1977). These assessment measures have been subjected to tests of validity and reliability but are mainly concerned with the gathering of information about populations rather than assessing the health of an individual and their needs for particular services (Fillenbaum 1982).

The distinction between population surveys of health problems by trained lay personnel and the assessment of needs of individuals by care providers is a crucial one and will be considered again in Part III. The identification of problems by surveys and questionnaires is only a starting point. There appears to be an assumption that all problems identified in surveys will subsequently be fully assessed and dealt with by health professionals. Even at the level of problem identification, there have been remarkably few attempts to validate assessment procedures as carried out by health professionals in the United Kingdom.

In Milne et al's (1972) study, a staff nurse was trained to examine

and question older people to detect physical and mental illness. Performance was found to be satisfactory in respect of accuracy and reproducibility. However, the tests were carried out in a clinic setting on a selected group of older people and they focussed on the detection of illnesses rather than functional capabilities.

Chamberlain (1973) found poor correlation between the assessment of older people at home by health visitors and their subsequent assessment in a clinic by medical specialists who carried out audiometric and other objective tests. The discrepancy between the two approaches is not surprising as the two methods of assessment differ fundamentally. The health visitors were testing complex skills such as the ability to conduct a conversation. Such functional ability involves the integration of a number of different elements, including cognition as well as the actual level of hearing measured by audiometry. Chamberlain's (1973) study is important in several respects. It further highlights the difference between the identification of problems and the subsequent assessment and analysis of these problems. It also raises the question as to which assessment is true. Her paper accepts the results of the objective tests as giving the true picture but the judgements of the health visitors may have been equally valid.

Ebrahim et al (1987) have examined inter-observer variation in interviews with older people and have obtained reasonably good levels of agreement between health visitors in their identification of health problems using a semi-structured approach to assessment. Their study shows that professionals can agree in assessing the needs of older people but the relevance of their study to everyday practice is not established. Two interviewers received special training, but the scope and content of their assessments have not been detailed and each interview took more than one hour to carry out. Nevertheless, this study is encouraging in demonstrating that agreement can be reached in identifying the health problems of older people at home by different professional observers.

It will be much more difficult to demonstrate that health assessments are reliable in the sense of specificity and sensitivity in detecting

health problems.

If the patients perception of health is accepted as an important criterion in assessing health care, then future studies concerned with the validity of health assessments will need to incorporate the patients judgement about the accuracy and relevance of the assessments.

EVALUATION OF ANTICIPATORY HEALTH CARE FOR OLDER PEOPLE IN THE COMMUNITY

If it is accepted that there continues to be a reservoir of unmet health needs in elderly people in the community, advocating case finding for identifying and meeting these health needs rests on the assumption that this group of people would benefit from such activity. However, there have been only a few attempts to evaluate the outcome of case finding in this age group.

In an early attempt to evaluate the benefits of the planned health assessment of older people, Lowther et al (1970) reported on 300 consecutive elderly patients who were seen at a consultative clinic. It was considered that 18-30 months after the first attendance, 29% still showed benefits from this type of activity. However, the subjects were a selected group, there was no control group, and the criteria of benefit were poorly defined and largely subjective.

Williams (1974) reviewed a group of 200 elderly patients one year after an initial health assessment in general practice. He found benefits in 27% of the patients studied but concluded that in only 8% was the benefit attributable to specific therapy. As in the study by Lowther et al, there was no control group and the criteria of assessment were again largely subjective.

Tulloch and Moore (1979) did carry out a study which included a control group. In their study one group of patients over the age of 70 received an assessment visit from a nurse and their subsequent progress was compared with a control group whose health was not assessed initially. Two years later assessment failed to demonstrate significant differences between the groups in socio-economic terms,

functional status or in medical disorders affecting health. There was a significant reduction in the duration of hospital stay in the study group compared with the control group and the study group remained independent longer than the control group. These benefits were accompanied by an increased use of both social and health services. This important study suffered from several drawbacks; the number of elderly people involved was small and they were possibly an atypical group. The paper does not describe the methods used to make the assessments of socio-economic and health status and no attempt was made to establish the validity and reliability of the assessments.

However, the findings of the study have been supported by the results of a similar but larger scale project by Hendriksen and colleagues (1984). They compared the outcome of assessment of older people in Denmark in a study in which a control group and an experimental group were followed up over a three year period. They found that the experimental group were admitted less often to hospital and were in-patients for shorter periods than the control group. There was no difference between the two groups in nursing home admissions, mortality or contacts with general practitioners.

Luker (1982), in a study of 230 elderly women aged 70 years and over studied the effects of health visitor assessment and intervention. An experimental group of elderly women received a visit from a health visitor once a month for four months. The health visitor focussed her attention specifically on the health problems which had been identified previously by a structured assessment carried out by another health visitor. The control groups also had their health needs assessed but did not receive subsequent visits from a health visitor during the study period. After four months, changes in the severity of identified problems were recorded. A life satisfaction measure was included into the assessment (Luker 1979). The control group then became an experimental group and received visits from the health visitor. At the end of the experimental period, the groups were asked for their opinion about the visits from the health visitor.

It was found that almost half of the problems improved in relation to

the health visitor involvement. Later assessments indicated that the effect of visits by the health visitor lasted after the service had been withdrawn. The assessment of benefit was largely subjective. The attempt to measure benefit using a life satisfaction scale was unsuccessful. The scale had been validated in a different context and for a different purpose. The measure was found to be insufficiently sensitive because it had not been designed to assess recent changes in health.

Thus, the studies which have attempted to evaluate the benefits of health assessments have produced more questions than answers. Objective benefits such as improvements in mobility have not been demonstrated. The utilization of services by older people appears to change in a complex way following the assessment of their health needs. There is an increase in the use of social services such as home helps, and an increase in the number of admissions to hospital following intervention but compared to control groups hospital admissions are for a shorter duration.

Descriptions of case finding often contain comments on the positive reaction to the intervention by the older people who are visited. In general, older people do welcome the interest shown in their health. This is important in itself even if objective criteria of benefit are not demonstrated because it may convince some older people who have low self esteem that they are worthy of attention and consideration. I could not find any studies which look in detail at the patients perception of case finding, other than that by Luker described above. Very few elderly people refuse to participate in case finding programmes in contrast to the relatively high numbers of younger people who fail to respond to invitations for health assessments.

PROBLEMS IN TEAMWORK

Doubts have been cast on the ability of the primary health care team to co-operate in co-ordinating their work to the optimum benefit of older people (Standing Medical Advisory Committee 1981, RCN 1982). Problems in the functioning of teams are not confined to care of the

elderly (Beales 1978, Reedy 1981), but the implications for the elderly are particularly important when they suffer from multiple disabilities and require help from different professions (Rushton & Winny 1979, Woods et al 1983). Milne (1979 and 1980) looked at the overlap in roles between different professional groups in the community. She found a large degree of overlap and suggested that this may be a possible cause of friction, particularly when an individual's perception of his own role differs from the role expected of him by other members of the team.

General practitioners and health visitors have very wide scope for deciding how they organise their working day. This results in wide variations in the patterns of work within each profession. For general practitioners, whichever aspect of their work is examined: referrals, investigations, consultation rates - a wide range is found (Wilkin & Metcalfe 1984). General practitioners are spending more time with older people as the percentage of the elderly in the community increases, but almost all of their contacts remain patient initiated (OPCS 1986).

On pages 9 & 10 I refer to studies which describe the wide variation in the percentage of total visits which health visitors make to the elderly. I concentrate on the work of health visitors because there has been an expectation that they are the key workers in the anticipatory care of older people (DHSS 1981, Williamson 1981, Brocklehurst 1982). Despite national recognition of the potential contribution of health visitors towards care of the elderly and despite the positive initiatives of individual health visitors in this area of their work (Loveland and Hillman 1971, Moore 1973, Kneer 1975, Day 1981), the Health Visitors Association placed a low priority on the planned and systematic detection of disabilities in the elderly in their document 'Health visiting in the eighties' (Health Visitors Association 1981). A joint policy statement by the Health Visitors Association and the British Geriatric Society (1986) is a sign that health visitors are beginning to give a higher priority to the care of the elderly.

The present job description of health visitors is seen by some as too wide and diffuse to be effective (Clark 1983), Barrett (1983) predicts

that regardless of demographic trends, health visitors priorities are likely to remain with children. She suggests that health visitors will have to decide whether to continue to fight for the right to visit all age groups, or admit that the present service to the elderly is inadequate and call for changes such as increasing the number of specialist health visitors for the elderly, or expanding the role of district nurses in their work with older people.

In general, health visitors appear to have reservations about visiting the elderly and they can easily opt to do other work (Hudson 1978, Dunnell and Dobbs 1982, Luker 1982, Tatham 1982). In view of the considerable scope which general practitioners and health visitors have in determining their own patterns of work, the attitude of these professional groups towards working with older people is of importance as is the influence of education in developing positive attitudes. The next section of the literature review considers attitudes and education.

ATTITUDES AND EDUCATION

The labelling of the literature in this field is itself of interest. Attitudes appear to have been considered to be stable characteristics which can be measured. Lutsky (1980) and Kogan (1979) have reviewed studies which have attempted to measure attitudes towards older people and they identify major inconsistencies between different studies. Lutsky (1980) suggests that these inconsistencies may be due not to the poor quality of the measures used but to the weakness of the concept of stable attitudes in this context. It may be more accurate and useful to think of attitudes of health workers working with older people as continually under revision as new information is provided about a particular aspect of the work. Older people form an extremely heterogeneous group and it should not be surprising that different views about different elderly subjects can be elicited as more information about them is provided (Brewer et al 1981).

Thus, it is important in measuring attitudes that the object of interest should be well defined. In most cases, studies which have

attempted to measure attitudes to the elderly have used simple generalizations such as 'old age' or 'elderly person', and have used these as interchangeable stimuli. Furthermore, responses have usually been measured along a single dimension, for example, positive/negative, rather than seeking to explore the complexity of feelings elicited by the stimuli.

It remains open to question whether responses to attitude questionnaires are in any way predictive of subsequent behaviour by the respondents. Examining the literature on the measurement of attitudes was helpful only in that it demonstrated that there is no single accepted method of measuring attitudes and that the results of any study in this field require to be considered in the context in which the study took place and even then interpreted with extreme caution. Overall, the studies reviewed by Lutsky (1980) and Kogan (1979) suggest that old age is viewed negatively by younger people.

Doctors and nurses receive little of their training in the community compared to the time spent in hospital. Multidisciplinary training is exceptional and members of the primary health care team have little shared educational experience before working together in the community. Care of the elderly in general and health assessment of older people in particular receive a low priority in the education and training of health professionals. A simple study by Gale and Livesley (1974) indicated that the feelings of medical students became more negative towards older people as they progressed through training.

Although all medical schools in the United Kingdom now include in the curriculum a period in general practice (Mackenzie Report 1986) and most do in geriatric medicine, it is not certain that an individual student will learn about or observe the assessment of an older person living at home during their training. Almost all the training which doctors do receive in the assessment of older people concerns the diagnosis of illnesses and pathological processes at a time of acute disturbance. Anticipatory care and the assessment of the effects of disability on the functional capabilities of older people are unlikely to be taught

in an explicit way to medical students unless the practices to which they are attached are enthusiasts in this field.

Undergraduate experience in geriatric medicine is hospital based and any visits to older people at home are likely to be at a time of crises when hospital admission is being contemplated. On average, medical students spend one month in general practice. Although many students will become aware of the possibility of including preventive care within general practice, the actual content and scope of health assessments of older people at home is unlikely to be covered in any detailed or systematic way.

A similar situation exists in the training of health visitors and district nurses. Although both groups receive classroom teaching on sociological aspects of ageing, health visitors may gain no practical experience in assessing the health needs of older people during their training year. If a visit to an elderly person does take place, this may be unsupervised and not evaluated. It is still possible for health visitors to complete their training without carrying out an assessment of the health needs of an older person.

Luker (1982) suggested that the reluctance health visitors show towards visiting the elderly may be due to them not being taught an appropriate frame of reference or agenda for dealing with this age group; they may lack a 'mental plan' for this area of work and may use lack of time as an excuse for avoiding it. Against this view, Fitton (1980) argues that health visitors are able to itemise plans for the purpose and content of visits to the elderly and some do appear to have created a structured approach to this part of the work. However, these plans are set out only in the most general terms and there is no evidence that the participants in her study actually carried out assessments in a planned and structured way.

The education of health professionals is a combination of theoretical courses and practical experience. The experience of working with older people in hospital may be unrewarding and negatively influence the views of health professionals (Gale and Livesley 1974, Wells 1980, RCN 1982).

This is not suprising. The frail ill elderly people in hospital are unrepresentative of older people in general. Some older people remain in hospital long after the acute phase of an illness has resolved because of the lack of resources for caring for them in the community. Such patients may be regarded by hospital staff as blocking beds and negative feelings about this may become generalised so that all older people are viewed as potential burdens for whom little can be done to alter their inevitable decline. The true state of affairs is not visible to a young hospital doctor or nurse. 95% of people over the age of 65 live in the community and the majority of them are active, independent and contributing members of society.

THE VIEWS OF OLDER PEOPLE ABOUT HEALTH CARE

If anticipatory care of older people is to be effective, it will require the active co-operation of older people. It is simplistic to make general statements about the attitudes and feelings of the elderly towards health care as older people are such a heterogeneous group but older people do appear to welcome invitations to participate in case finding programmes. As mentioned previously, very few older people refuse to participate in health surveys and the appreciation by the elderly of the interest shown in their health and welfare is one of the reported benefits of case finding in this age group (Williams 1974, Tulloch & Moore 1979).

Organisations who represent older people are starting to voice their expectations of the health services. Age Concern (1986) considers that, in view of the demographic changes in the population, it is now appropriate to consider priorities in providing health services from the perspective of the older person as a consumer of services. In particular, Age Concern advocates that older people should be offered an assessment of their health each year. However, as yet, older people have little or no say in the decisions about allocation of services in primary health care. Many older people are not well informed about the type of help and the range of services which should be available. A WHO (1982) report notes that in developed countries such as the United Kingdom expensive and often inappropriate health services may be provided for older people in hospital, whilst much needed and less

sophisticated services such as home helps, chiropody and dental treatment are inadequate.

It is difficult for older people to have a view about preventive health care services if they don't know what the different members of the primary health care team do. Ritchie et al (1982) found that 62% of people over the age of 65 who had not yet received a visit from a health visitor did not know what she did and this percentage was even higher at 83% if only people aged 75 years and over were considered. Only 2% of this group thought that care of the elderly was part of her work. Luker (1981) in her study found that the majority of elderly women who received visits from a health visitor enjoyed them and felt they benefitted in some way from them. The social aspects of the contact and having 'someone to talk to' were valued.

SUMMARY

UNMET HEALTH NEEDS

Most of the studies into the health needs of older people in the community have identified health problems which were unknown to the general practitioner and not recorded in the medical notes. A few studies which have not revealed unmet health needs have taken place in rural or affluent suburban areas of the country.

PATTERN OF CONTACT BETWEEN OLDER PEOPLE AND PRIMARY HEALTH CARE SERVICES

The failure to detect health problems in the elderly is not due to lack of contact between older people and their general practitioner. Consultation rates for older people with their general practitioner are high.

In contrast, few older people are seen by a health visitor and visits to the elderly on average form a low proportion of the health visitor's time and workload and is not increasing. There is extremely wide variation between health visitors in the amount of time they spend with the elderly. This appears to reflect personal preference more than differences due to regional policies or the priorities of work for health visitors.

Although district nurses spend a high proportion of their time with older people, their patients form only a very small percentage of the total elderly people in the community.

CASE FINDING AND SCREENING

There may have been a secular change in the pattern of health problems which are unknown to the general practitioner and discovered during surveys of older people. There has certainly been a change in the focus of interest in the surveys of health needs in this age group from a search for presymptomatic disease towards the detection of established but previously unreported or unrecorded disabilities. The former is referred to as screening and the latter as case finding in this thesis.

VALIDITY OF HEALTH ASSESSMENTS

Many different schedules and protocols for the detection of disabilities affecting older people have been used in the published surveys. The few which have been subjected to tests of validity and reliability have been designed for use by lay interviewers and have limited aims in crudely identifying health problems. These approaches seek to describe the health needs of populations rather than provide care to individuals. Health assessments by doctors, health visitors and nurses attempt to progress beyond the level of identifying problems. Such assessments seek to define and analyse problems and assess their importance to the individual elderly person.

EVALUATION OF CASE FINDING IN THE ELDERLY

The few studies which attempted to assess the reliability of health assessments by health professionals have found this to be a difficult task due to the difficulty in establishing objective criteria which are themselves accepted as valid.

In consequence of the problems in establishing the validity of health assessments, the studies which have attempted to measure the benefits of case finding by health professionals have used different and unvalidated interview schedules. Comparisons between the different studies are therefore hazardous. In general, it has been found that older people welcome and appreciate the assessments and this gives a subjective benefit. Clear objective improvements in functional status have not been demonstrated. As a result of case finding, there is an increase in the uptake of health and social services by the elderly and possibly fewer older people require to be admitted for long term residential care than would otherwise be the case.

TEAMWORK

There are doubts about whether the different health professions can effectively combine and co-ordinate their work with older people. Overlap in roles and wide variations in the personal preferences of individuals in setting their priorities may be barriers to effective

teamwork. The role of health visitors has been the subject of most comment because of expectations that they are the key workers in anticipatory care of the elderly and because they have the greatest scope of all the health professions in determining their own working patterns.

ATTITUDES AND EDUCATION

The literature on attitudes casts doubt on the validity of the concept that there is a consistent and sustained view of working with older people in the minds of health workers. Providing more information about particular elderly people has been shown to change responses indicative of attitudes. The context in which people work and the characteristics of individual patients are likely to influence the views and feelings of the doctor, health visitor or nurse involved.

There is some evidence that feelings towards working with older people becomes less positive as health workers proceed through training. This is not surprising. Most of the early educational experience of medical and nursing students is in hospital and in wards where elderly patients may be considered by senior staff to be inappropriately placed. The education and training of doctors, health visitors and nurses in the anticipatory care of older people is haphazard. It is possible for all the professional groups to qualify and enter practice without experience in this activity and without being examined on their knowledge or performance in case finding. Although different professional groups are involved in the assessment of older people, multidisciplinary education in this field is exceptional.

VIEW OF OLDER PEOPLE ABOUT HEALTH ASSESSMENT

Organisations who represent the views of older people, such as Age Concern, actively campaign for the implementation of routine 'health checks' for the elderly. There are very high acceptance rates by older people who are invited to participate in case finding programmes. There is evidence that older people do not understand the role of health visitors in relation to their own age group.

Although Age Concern recommends that older people as consumers should be consulted about the patterns of services provided for them, their views on the content of health assessments or how they should be carried out have not been sought.

EXPLORATORY STUDIES

In 1982 after I first reviewed the literature, I wished to devise a method of case finding which could be used by health visitors and which could be shown to be valid and reliable. From an examination of the protocols used in previous studies, it was possible to identify categories of assessment which were common to most of them. Missing from previously published work was information about the way in which health personnel who were unconnected with research teams actually carried out health assessments of older people at home. Before devising a case finding package for use by health visitors, I arranged to: interview health visitors who were carrying out regular health assessments of older people; examine in detail how a health visitor and myself as a general practitioner carried out health assessments by video-recording interviews with six elderly women in their own homes; and ascertain how health visitor students envisaged assessing the health needs of older people.

INTERVIEWS WITH HEALTH VISITORS

The interviews took place in three health board areas in Scotland. Through local contacts in general practice, community medicine and health visiting, I knew of three markedly different approaches by health visitors to the anticipatory care of older people. These different approaches were: the appointment of a specialist health visitor for the elderly; the implementation of a specific Health Board Policy of regular surveillance of the elderly by health visitors; the maintenance of a case finding programme in a single health centre by health visitors who had long term experience of operating a method based on research carried out by Barber and his colleagues (1976, 1980). Permission to interview the health visitors concerned was readily given by the nursing officers involved. The overall tone of the comments from the nursing officers and the health visitors indicated an enthusiasm for providing a service for older people but uncertainty about the most effective way of organising care.

HEALTH VISITOR TO THE ELDERLY

Lothian Health Board on an experimental basis had appointed a health

visitor who had a commitment to work full-time with older people in a defined geographical area. She was expected to visit elderly people herself and also to stimulate interest by general practitioners and other health visitors in case finding in an underprivileged part of the city of Edinburgh.

At the time of her interview she had been in post for one year. In her area, there are four practice premises and many other practices have patients in that part of the city. There was a mixture of practice based and area based health visitors and she needed to relate to more than ten other health visitors on a regular basis in order to identify people whom she should visit and to be able subsequently to refer back cases. She voiced frustration in her work because of difficulties in communicating with local general practitioners. Other health visitors in the area appeared to be overwhelmed by the needs of families with young children. They felt relieved that someone else was visiting the elderly and could not see how they could devote more time to this activity themselves. In general, the health visitor to the elderly felt that there was a lack of interest by other members of the primary health care team in the health problems of older people which she had identified.

It was noted that the experimental health visitor had created a structured approach for her own health assessments of older people at home.

HEALTH BOARD POLICY

The Fife Health Board in 1981 agreed a policy for promoting anticipatory care for older people. Consequently, senior nursing officers and community medicine specialists were encouraging and supporting health

visitors and general practitioners to undertake regular surveillance of the health needs of older people. It was hoped that a central computerised record system would enable this activity to be monitored and evaluated. The initiative was at a very early stage and three health visitors who were involved in a pilot scheme were interviewed. They were apprehensive about the amount of paperwork which might be required of them and doubtful of the value of accumulating and processing data centrally.

The health visitors anticipated that there would be considerable differences in the feasibility of undertaking systematic case finding between different communities. They considered that these differences would depend not only on the characteristics of the population but also on the views of particular general practitioners, district nurses and health visitors. (Subsequent information indicates that these fears were justified. Case finding in Fife has developed in a patchy manner in spite of active encouragement by the Health Board).

SUSTAINING A CASE FINDING PROGRAMME

Health visitors in Woodside Health Centre in Glasgow have had experience in maintaining case finding programmes which originated in the work of Barber and Wallis (1976). Three health visitors were interviewed. Each of the health visitors had been in post for at least three years. They reported that the case finding schedule devised for the research study had been shortened and modified according to the particular preferences of individual health visitors. These health visitors also were concerned about the amount of paperwork generated by standardised protocols and they had doubts about whether the information they gathered and passed on to general practitioners was acted upon.

CONCLUSIONS

From these informal interviews, I formed the view that case finding by health visitors could not be sensibly viewed in isolation from the functioning of the primary health care team. Even if one profession takes the responsibility for carrying out initial health assessments it is inevitable that referrals to the other professions will occur.

If poor relationships and poor communication between different health workers and different professional groups exist, case finding is likely to be fragmented and inefficient.

Although the interviewed health visitors saw themselves as taking a leading role in the assessment of health needs in older people, the high referral rate (Freedman et al 1978, Barber and Wallis 1978) to all professional groups means that expertise in this area of care is required of all health personnel. The multidisciplinary aspects of health assessment have not previously received much attention (Bowling 1983).

The health visitors were worried that the implementation of systematic case finding could result in a considerable amount of paperwork and generate data without this necessarily leading to effective action. The health visitors seemed to be suspicious of protocols and when provided with them, had adapted, shortened and modified them to suit individual circumstances. However, they did appreciate being provided with a framework of assessment on which they could build.

The different types of organisation of case finding activity in the three health board areas emphasises that there is no standard accepted approach to anticipatory care of older people.

VIDEO RECORDINGS OF ASSESSMENTS

In the next part of the exploratory study, six elderly women were identified and interviewed. Two were selected from my own new town practice and the other four selected by another general practitioner from his city practice. From an examination of health records and the personal recollection of their general practitioners, they were known to have a number of health problems but not to be acutely ill at the time of the interview. Each person was assessed by their own health visitor as being able to accept the intrusion into their homes of the research interviewer and the technical staff required for the recordings. The details of how the women were contacted and how they gave permission for the recordings to be made and used are contained in appendix VII.

The focus of interest at this stage of the study was on health assessments as carried out by a health visitor and four of the interviews were carried out by a health visitor and two by myself. Each interview took approximately 45 minutes.

The recording of health assessment interviews with older people in their own homes was found to be feasible and acceptable. One woman was upset by her own appearance when she saw herself on the recording, but the other women reacted in a completely favourable way. The women responded at length to questions and each pursued a unique route through the assessment interview. In two of the interviews attempts were made to follow a set series of questions but this was found to be restrictive by the interviewer and was resisted by the interviewees.

The recorded interviews contained elements which were highly charged emotionally, ranging from tears to laughter. Important qualitative aspects of health assessment were apparent in the video-recordings and might have been missed using other techniques of reporting the content of interviews.

HEALTH VISITOR STUDENTS

Excerpts of the video-recordings of interviews with older women were shown to a class of 35 health visitor students on the last day of their course. This was done in an informal way in order to gain some idea of their views about the health assessment of older people at home at a crucial stage in their career.

The video-recordings proved to be a challenging and stimulating educational method which revealed conflict in the minds of the students about their future role as health visitors, and uncertainty about the content of health assessments of older people at home.

There was a sharp division between students who saw health visiting as an extension of nursing and those who saw their future role as more akin to social work. This division came to light when one of the recordings showed the health visitor removing the stocking of the elderly woman in

order to examine an abrasion. Several students expressed the view that this was inappropriate action for a health visitor. Other students considered this action to be a normal part of their work and vigorous debate between the students took place.

The uncertainty of the students about the scope and content of assessment and their apparent ambivalence about working with the elderly suggested that useful information would be gained by a systematic enquiry into these areas. Showing a small excerpt of a video-recording of an interview with an elderly woman was found to be effective in eliciting views and opinions in a short time.

AIMS AND OBJECTIVES

Following the exploratory studies and the review of the literature, I considered it was necessary to redefine the aims of my research. When I set out on this enquiry, I had hoped to be able to devise and test a method of case finding in the elderly population which would be used by health visitors.

The review of the literature initially encouraged me to pursue this aim. Most studies support the idea that there continues to be a reservoir of unmet health needs in the elderly population in the community. The few attempts which have been made to evaluate the possible benefits of case finding programmes are inconclusive because the health assessments used to identify needs and measure the outcome of interventions have not been demonstrated to be reliable or valid. Developing and testing a reliable and valid method of assessment therefore seemed to be both necessary and important.

However, the exploratory studies caused me to question the feasibility of implementing a validated method of assessment. Interviews with health visitors experienced in the use of a standard protocol of assessment demonstrated that the protocol was shortened and modified for use in routine practise. Video-recorded assessment interviews with older women at home showed that each interview was unique and attempts to follow a set series of questions were found to be restrictive by the interviewer and resisted by the elderly women. The comments of health visitor students who were shown excerpts of the recorded interviews revealed that there were major uncertainties within this group of students at the end of their course about the scope and content of health assessments of older people and about their role in relation to older people and to other health professions.

I had hoped to be able to frame my research questions in the form of hypotheses but my interest in health assessment has become more, rather than less, diffuse as a result of the exploratory studies.

I considered that the necessary first steps in creating a systematic approach to the anticipatory care of older people in the community were to gain a greater understanding of the nature of health assessment and to discover whether there was a concensus about the scope and content of such assessments within the professional groups concerned and whether this concensus view was shared by older people themselves.

The review of the literature and the exploratory studies also caused me to have doubts about the willingness of health professionals to be involved in programmes of anticipatory care for older people in the community and about the ability of these professional groups to work effectively together in this part of their work.

I believed therefore that, for initiatives in the anticipatory care of older people to progress from being sporadic and short-lived, it was important to gain knowledge not only about the scope and content of health assessments but also about the feelings of health workers towards this aspect of their work and about how members of the primary health care team perceive the contribution of their own and other health professions to this activity.

It was on the basis of these considerations that the following aims and objectives of the research were constructed.

AIMS

The studies in Part II seek to:

1. Describe the scope and content of health assessments of older people at home as perceived by different professional groups and by older people themselves.

2. Provide information on the views and feelings of different professional groups towards visiting and assessing the health of older people at home.

3. Describe how different health professions perceive their own role and the role of others in assessing and responding to the health needs of older people at home.

OBJECTIVES

More specifically, the studies described in Part II attempt to answer the following questions which are linked to the three aims:

1a. Do health professionals perceive the health needs of an old person living at home in the same way?

1b. What elements do health professionals wish to include in the health assessment of an older person at home?

1c. Do health professionals have a structure for their assessment of older people at home?

1d. Can a framework of assessment be defined which is common both to the different health professions and to older people themselves?

1e. Do the concepts of students about the scope and content of health assessments change during training?

2a. Are health professionals positive in their attitude towards working with older people at home?

2b. Does training influence attitudes?

3a. Does the view of the role of one professional group in its work with older people as perceived by other professional groups accord with that profession's own perception of their role?

PART II

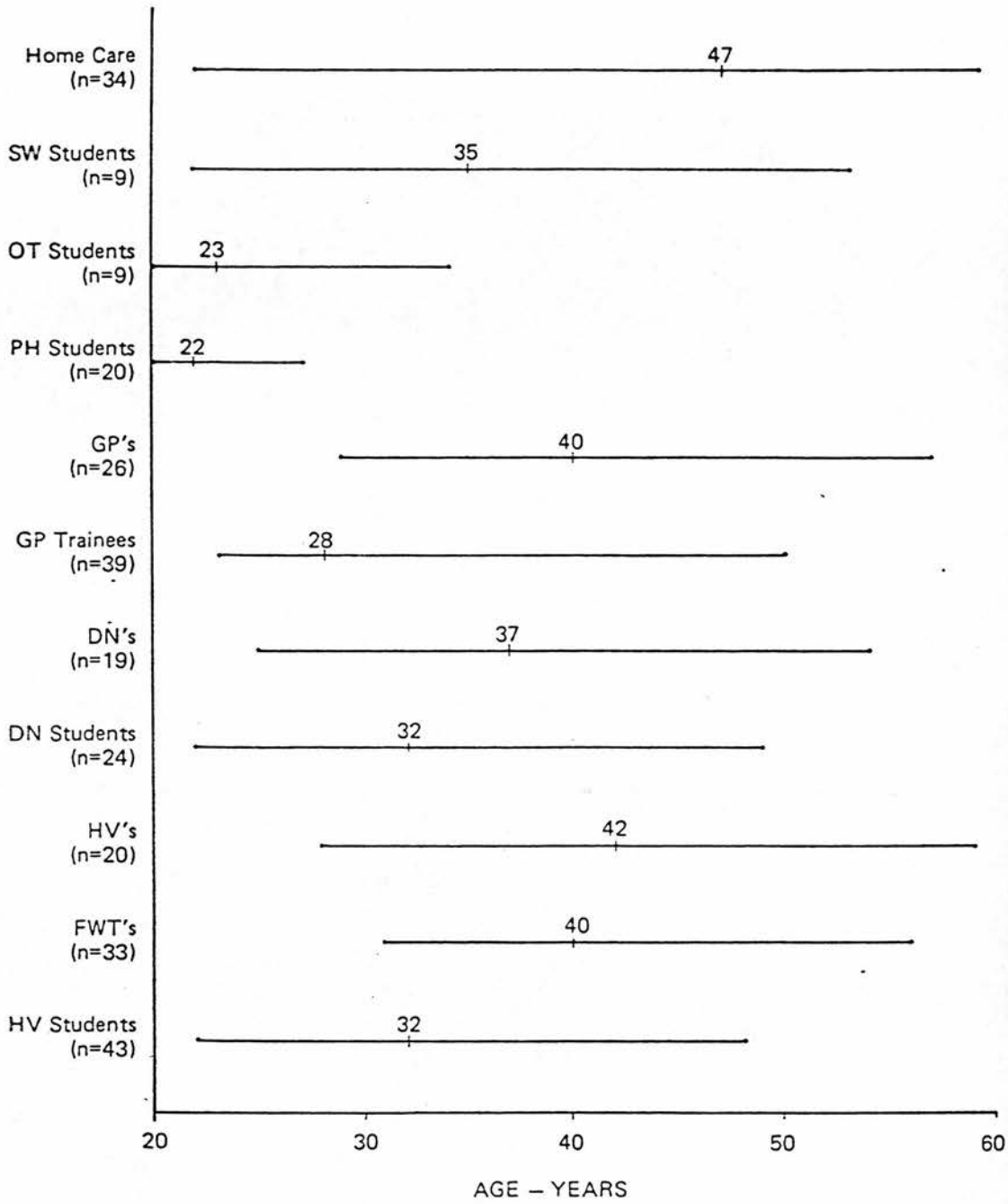

Figure 1 Age range and mean for each group of study participants.

PART II

STUDY GROUPS

The literature on anticipatory care in the elderly in the main describes the work of health visitors, general practitioners, and nurses. However, many other groups are also involved in assessing the health needs of older people and I wished to learn from as many different groups and individuals as possible. Eventually, eleven professional groups and two groups of older people participated in this study. The professional groups were:

1.	Student health visitors	(43)
2.	Health visitors	(20)
3.	Field work teachers (health visitors)	(33)
4.	Student district nurses	(24)
5.	District nurses	(19)
6.	General practitioner trainees	(39)
7.	General practitioners	(26)
8.	Student physiotherapists	(20)
9.	Student occupational therapists	(9)
10.	Student social workers	(9)
11.	Home care organisers	(34)

( ) number in each group

Although this was a larger number of different groups than has previously been considered in this field, there were important omissions. Community psychiatric nurses and experienced groups of social workers, occupational therapists and physiotherapists were missing from the list.

Apart from the small groups of occupational therapists and physiotherapists, there is a surprising degree of overlap in the age ranges of the different study groups (figure 1). This indicates the wide variation in experience within the groups of health visitor students, district nurse students and general practitioner trainees.

DETAILS OF STUDY GROUPS

STUDENT HEALTH VISITORS

Forty-three student health visitors participated in the video studies during the 1981/82 twelve-month course at Queen Margaret College, Edinburgh. This college is one of 11 Scottish Central Institutions which are grant aided by the Scottish Education Department. It provides a range of advanced courses in health service work including nursing, physiotherapy, occupational therapy and speech therapy. In addition to the health visitor students, other students studying at the college at that time for the district nurse certificate, the diploma in physiotherapy and the diploma in occupational therapy also took part in the research.

Within the group of health visitor students there was wide variation in their previous experience. Eleven of the students had previously worked as district nurses and a further ten appeared to have selected work which was mainly with the elderly in geriatric wards or nursing homes.

EXPERIENCED HEALTH VISITORS AND FIELDWORK TEACHERS

Two groups of experienced health visitors took part in the study and they differed in several ways. The fieldwork teachers had responsibilities for supervising the practical experience of students and health visitors. They were invited to take part in the research while attending a study day at Queen Margaret College. They were thus not selected on the basis of a particular interest in work with the elderly. It soon became apparent in discussion that their views and feelings about working with older people ranged from enthusiasm to guilt and uncertainty. Their written remarks which illustrate their views and feelings are discussed later. The other group of experienced health visitors did not have fieldwork teaching responsibilities. They were a self-selected group, having responded to an invitation distributed by community nurse managers in three districts of Lothian Health Board. The invitation indicated that the meeting would be about their work with the elderly and stated that participation in research and discussion about the role

of the health visitor in the care of the elderly would be included.

Not surprisingly, this group contained a number of health visitors who had extensive previous experience of working with older people, for example, six had been charge nurses in geriatric wards and a further six had worked as district nursing sisters. The interest within this group towards work with the elderly was also reflected in the number who considered that they had special responsibilities related to the care of the elderly in their present post. Eight of the health visitors described themselves as being involved in 'at-risk checks of the isolated 75 to 85 year olds' or 'screening of 65 plus'. Three of the health visitors undertook hospital/community liaison work, two of them on a full-time basis working from hospital and carrying out assessments following referral from consultant geriatricians. Two of the group described themselves as specialist health visitors for the elderly. One had a case load of 80% elderly and 20% young families, the other had been appointed to a group practice in an area of urban deprivation. It was striking that this latter health visitor's response to the video studies differed from those of her colleagues in its greater depth and detail of written comment.

STUDENT DISTRICT NURSES

This group was also attending Queen Margaret College and comprised all 24 of the 1981/82 class of students. Nine of the group recorded previous nursing work with elderly patients, mainly as charge nurses or staff nurses in geriatric wards. Two of the students had worked as health visitors. One remarked that she hoped to get more fulfilment in caring for the elderly as a district nurse.

EXPERIENCED DISTRICT NURSES

Nineteen district nursing sisters responded to the same invitation as that offered, via community nurse managers, to experienced health visitors. Ten in this group recorded previous nursing work with elderly people. The range of experience within district nursing was very wide, ranging from one to 21 years. Two were working in combined

district nurse/midwife posts but both estimated, as did the rest of the group, that 75% or more of their work was with the elderly.

TRAINEE GENERAL PRACTITIONERS

The fifty trainee general practitioners were attending a release course as part of their formal educational programme. The total number of trainee general practitioners in the Region at the time was 70 and attendance at the session was average for the year. It was not advertised as dealing with the elderly and the sample is likely to represent the trainees who normally attend the release course and likely also to be a reasonable indicator of trainees in the Region. Because of the late arrival of some of the trainees, only 39 completed the questionnaire whereas all 50 participated in the video studies.

EXPERIENCED GENERAL PRACTITIONERS

The group of 26 experienced general practitioners were attending a residential course of a week's duration which dealt with the care of the elderly in the community. The group could therefore not be considered representative or typical of general practitioners as a whole. Only four of the doctors were not in teaching practices.

STUDENT PHYSIOTHERAPISTS AND OCCUPATIONAL THERAPISTS

The 20 physiotherapy students and nine occupational therapy students were nearing completion of their three year diploma course at Queen Margaret College. All had some field work experience with elderly people in hospital and at home but their previous personal and professional experience of dealing with elderly people was limited. Both groups were young in comparison to the other groups and most of the students had come to that course direct from school.

STUDENT SOCIAL WORKERS

An invitation was sent in June 1982 to students nearing completion of one and two year postgraduate courses leading to the certificate of qualification in social work at the University of Edinburgh. All the students were on field work practice at the time and only a small self-selected group of nine chose to attend, all of whom expressed a

particular interest in working with older people.

HOME CARE ORGANISERS AND SUPERVISERS

With the agreement of Lothian Region's Social Work Department, invitation was sent in May 1982 to all home care organisers in the region to attend a meeting of the same format as that organised for the other study groups. Home care staff were keen to participate in the study as there was concern at the time about existing assessment schedules and training.

Thirty-four home care organisers participated in the study: six divisional fourteen area and fourteen assistant area home care organisers.

ELDERLY PEOPLE ATTENDING DAY CENTRES

Two day centres were approached because of personal links with each of them. They were selected because of their contrasting locations and organisations. One was in the new town of Livingston and had been created by the efforts of the Old People Welfare Committee with the aim of providing social stimulation for the housebound elderly and relief for their carers. Transport was therefore provided for all attenders. The other centre was in Dunbar and one of the local health visitors was particularly active in its operation. Elderly people made their own way to the centre. A total of 31 elderly people attending the centres on the particular day participated in a shortened form of the study. No prior selection of the older people was made. The age range was 68 to 89 years. At the centre in Livingston many of the older people required help from the study team in recording their responses to the video because of frailty and poor sight. At the other centre in Dunbar the group of elderly people appeared to be fit and few required help to record their responses.

SUMMARY

It cannot be claimed that the groups studied are representative of their professions. The experienced health visitors, district nurses and general practitioners were self-selected as being interested in the care of the elderly. The field work teachers and general practitioner

trainees were the majority of the total group for South East Scotland and may therefore be more representative. Similarly, the class groups of health visitor, district nurse, and physiotherapy students may be reasonably representative. The social work and occupational therapy students were small groups and self-selected. The home care organisers were nominated and also self-selected but comprised the majority of such workers in Lothian region. The two groups of older people are unlikely to be representative of the total elderly population because they were selected on the basis of attending day centres which is a minority activity.

There were considerable differences between and within groups in educational and professional background and in work experience. Some of the sample had considerably more opportunity than others because of age and experience to learn about contact with older people.

EXTENT OF PARTICIPATION

All the professional groups completed a questionnaire (details of which are given in appendix IV.) The questionnaire enquired into the personal and professional background of the respondents and about their views and feelings towards visiting older people at home.

All groups, including the two groups of older people, saw the first video excerpt. All professional groups, except the student physiotherapists, occupational therapists and social work students, saw the second video excerpt and all the professional groups saw the third video excerpt.

The student health visitors and student district nurses repeated the study at the end of their courses.

The methods were found to be of interest to all groups and the exercise could be completed within one and a half hours. For all the groups the research procedure was followed by a general discussion.

STUDIES USING EXCERPTS OF VIDEO RECORDED INTERVIEWS

INTRODUCTION

In the exploratory study involving the student health visitors, excerpts from recorded interviews between a health visitor and elderly women in their own homes were found to be a potent means of stimulating the students to express their views in a clear and forthright way. The excerpts provided a standard stimulus to the different groups including the two groups of older people. The excerpts showed a real person with real problems. The literature on studies into attitudes towards other people had demonstrated the difficulty interpreting the responses in studies which had used general statements of old age as the stimulus.

I wished to use a stimulus which was not only standard but also specific. This can be critised on the grounds that the responses of participants who are shown one older woman at home may be of relevance only to that woman. In addition, although standard, the stimulus provided by the recorded excerpt is complex and respondents may be reacting to different elements contained in the recording. However, these problems also occur in the actual work of the participants. This raises the fundamental problem which recurs throughout the thesis and throughout clinical practice: the extent to which assessment can and should be uniform and the extent to which it requires clinical expertise and judgement. Part III of the thesis considers this issue further and defends the choice of the methods described below.

METHODS

SELECTION OF EXCERPTS

The excerpts selected were chosen in order to try to elicit different types of responses. Transcripts of all six interviews were made. This helped in identifying excerpts which contained enough information in a short time so that participants could observe important health problems. In showing the first excerpt I wished to pursue aims 1 and 3 by ascertaining:

a) the perceptions of participants about common problems affecting older people,

b) the ideas of participants about the scope and content of their own health assessment of older people,

c) how participants viewed the contributions of different professions in caring for older people in the community.

The second excerpt also was designed to provide information relevant to aims 1 and 3 but on this occasion attention was focussed on one common clinical problem and participants were asked to consider how health visitors would assess and manage this problem. The health visitor has been put forward as the key worker in this area of care and I wished to see if there was agreement between the views of other professions and health visitors themselves about the nature of their role in working with older people.

VIDEO EXCERPT 1 - MRS C

Excerpt 1 was the first three and a half minutes of an interview with an elderly lady and showed her moving with difficulty from one chair to another, when she began to describe some of the problems she experienced. Appendix II is the complete transcription of this excerpt. She refers to problems with balance, kneeling, arthritis and a collapsed fracture. The interviewer indicates that the elderly woman lives alone.

This excerpt was selected to set the scene for an assessment visit to an older woman who is frail and lives alone and is likely to have multiple health problems. Participants were asked to consider from the point of view of their own professional role the questions put to them after seeing the video recording.

Before showing the excerpt, the participants were given the following information:

'The doctor on duty the previous night says he has seen Mrs C, an 84 year old widow, who has fallen. Fortunately, there is no serious injury. The doctor asks you to visit her. She is not previously known to you.'

The 3½ minute video-recording was then shown.

Question 1 and 2 - sheet number 1.

'What have you seen and heard of significance? List your observations. What actual and potential problems do you think Mrs C has?'

Participants were allowed up to seven minutes to complete this sheet.

The purpose of the questions was to try to find out how different individuals and different professional groups perceive the elderly and their problems.

Question 3 - sheet number 2.

'At the end of your interview, what areas of assessment would you wish to have covered? List the areas.'

Up to ten minutes was allowed for completion of this sheet.

This question sought to ascertain how the different groups described the scope and content of health assessments.

The two groups of older people were shown this recorded excerpt of the interview and their responses to question 3 were compared with those of the other groups.

The participants were then given the following further information about Mrs C:

'She wishes to stay in her flat. She does not wish to have a home help. Her niece says that she can visit daily. She is discussed at the practice team meeting.'

Questions 4 to 8 - sheet number 3.

'Should she have regular visits? If no, why not? If yes, for what reasons? If yes, how frequent should visits be?'

Although five minutes were allowed for these questions in total, all participants were able to respond within a much shorter time.

The purpose of these questions was to discover in practical terms how participants viewed their own role in relation to visiting older people and the role of other professional groups.

VIDEO EXCERPT 2 - MRS W

In this excerpt a different elderly woman described the medicines which had been prescribed for her and how she took them. In contrast to excerpt 1, questions relating to this recording asked participants to look at a particular problem for older people and specifically consider the role of a health visitor in dealing with this problem. Medicine taking was selected because this is a common problem for older people and is undoubtedly within the province of health professionals.

The participants were given the following information:
'Mrs W is a 78 year old widow who lives alone. She has been affected for five years by congestive cardiac failure and angina for which she is prescribed a diuretic, a potassium supplement and a long acting anti-anginal drug'.
'Ten days ago she was discharged from the hospital outpatients clinic after recovering from pneumonia and no new drugs were prescribed. You are aware that she has previously taken her medicines irregularly.'
'You visit her.'

A two minute video recording was then shown.

Question 1 - sheet number 1

What problems in her medicine taking are demonstrated? Please list the problems.

Question 2 - sheet number 2

Which area of a health visitors assessment of this lady will be relevant to her medicine taking? Please list the areas.

Participants were then given the following further information:

'There are two lists about her drugs which do not correspond with each other or with the labels on the bottles. She says she takes the medicines as indicated on the bottles but has difficult reading the labels. She does not know the purpose of her potassium supplements or anti-anginal drug and mixes up these tablets. She continues to have chest pain on climbing stairs but is able to get to the doctor's surgery and to the chemist. She shows no evidence of memory impairment. She can swallow medicines and is able to open the containers. She is continent.'

Question 3 - sheet number 3

What would you expect the health visitor to do in order to improve medicine taking by this lady? List the most important things (not more than four).

Completion of these three questions took in total not more than fifteen minutes.

METHOD OF SCORING RESPONSES TO QUESTIONS FOLLOWING EXCERPTS 1 and 2

Student health visitors were the first group to answer the series of questions described above. From their responses, scoring sheets were devised. The descriptions of problems and assessment items given by the students were listed within major categories and their subdivisions. For example, the major category of mobility contained four subdivisions as responses to question 1 following video excerpt 1 and nine sub-divisions in the responses to question 3. Because the questions were open ended, responses were allocated to categories and subdivisions by scrutinising the sheets. This was a tedious task which was made more difficult by poor hand-writing. However, this approach avoided introducing any bias into the responses. In order to check the reliability of the allocations of responses to the categories and/or the subdivisions, two scorers independently scrutinized the papers and allocated the responses to categories and subdivisions. The scoring sheet was developed by listing and categorising all answer items by the health visitor student group. New items were added if required when scoring the responses from other groups.

As an indication of the range of responses, there were 170 distinguishable items for the first two questions and 235 for the third question. These items were collected into 46 categories. The categories, and details of the most frequently occurring subdivisions within each category are given in appendix III.

ERROR RATES

A sample of responses from questions 1, 2 and 3 were analysed independently by two observers and results compared.

There were four sources of error; transcription errors, item omissions, and within and between category differences in interpretation. The interpretation of responses was influenced by the style of answering, by the level of precision of meaning and by the legibility of responses.

In answering the questions 1 and 2, most participants listed clearly the observations and problems in two columns, but some gave a descriptive, narrative account which made interpretation difficult. Many did not distinguish actual from potential problems.

To improve the scoring, and to reduce error rates which were from 0.6 per cent to 5 per cent (table I) all responses to questions 1, 2 and 3 were scored by two observers independently. Errors and omissions were corrected and agreement reached for within and between category differences.

Table I Mrs. C. Questions 1, 2 and 3. Percentage of scoring errors in each group

Group	No. in group	Total No. of items scored Q, 1 & 2	Error rate %	Total No. of items scored Q.3	Error rate %
HV students	43	594	1.3	1043	0.6
FWT	33	513	2.0	695	2.8
HV	19	375	2.9	565	2.3
DN students	24	384	3.9	492	3.0
DN	20	301	2.3	363	2.3
GP trainees	48	710	5.0	962	4.1
GP	29	353	4.8	394	4.3
PH students	20	337	1.6	441	5.0
OT students	9	152	2.9	231	3.8
SW students	9	179	5.0	235	3.0
Home care	34	369	3.8	384	2.3

Responses in each of the 46 categories were transferred to punch cards for further analysis.

(Question 4 for Mrs. C and the three questions for Excerpt 2 - Mrs W were much easier to interpret and score as the range of response was narrower and the precision greater. The error rate for these questions was less than one per cent.

RESPONSES TO QUESTIONS 1 AND 2 - OBSERVATIONS AND PROBLEMS

There were marked differences in the ways in which Mrs C and her surroundings were perceived. For example, she was variously described in terms of mood and attitudes as cheerful, depressed,

anxious, stubborn, bored, lonely, withdrawn, dogmatic, proud, realistic, apathetic and having a sens of humour. She was seen to be neat and tidy and well dressed but also unkempt. Her room was described as cluttered and uncluttered and the house as suitable and unsuitable.

The number of observations and problems given varied within and between groups. Table II shows the range and mean number for each group (overall mean = 8 for observations and 7 for problems).

Table II Mrs C. Questions 1 & 2. Range and mean number of observations and problems given by each group

Group	Observations		Problems	
	Range	Mean	Range	Mean
HV students				
early	4-14	7	3-13	6
late	1-17	7	4-17	8
FWT	2-17	11	0-20	5
HV	4-15	9	2-18	9
DN students				
early	6-16	9	2-13	7
late	5-20	10	7-13	10
DN	5-14	8	3-12	8
GP trainees	0-12	8	2-14	7
GP	3-13	6	1-12	6
OT students	5-11	7	7-13	10
PH students	4-15	8	2-16	9
SW students	4-15	10	5-17	10
Home care	2-14	7	-12	4

The experienced GPs and the home care organisers tended to make fewer responses than other groups. The fieldwork teachers itemised many observations but few problems.

Similarity and differences between groups can be seen in Tables III & IV which show the categories of observations and problems in which half or more of each group responded.

Table III Mrs C. Question 1 - Categories in which half or more of each group made an observation

Category of Observation	HVSte	HVStl	FWT	HV	DNSte	DNStl	DN	GP Tr	GP	OT St	PH St	SW St	HC
Mobility	*	*	*	*		*	*	*	*	*			*
Balance	*	*	*	*	*	*	*	*	*	*	*	*	
Aids for Mobility	*			*	*	*				*	*	*	
Transferring				*						*	*	*	
Vision	*	*	*	*	*	*				*	*	*	*
House			*	*		*	*	*			*	*	
Isolation			*	*	*	*	*	*	*	*	*	*	
Mood												*	
Bereavement												*	
Attitudes												*	
Relatives				*								*	*
Social Support												*	
Physical signs	*	*	*	*	*	*	*	*		*	*		

Table IV Mrs C. Question 2 - Categories in which half or more of each group identified a problem

Category of Problem	HVSte	HVStl	FWT	HV	DNSte	DNStl	DN	GP Tr	GP	OT St	PH St	SW St	HC
Mobility	*	*	*		*	*	*	*	*	*	*	*	
Balance				*						*	*		
Falls				*				*			*		
Transferring										*	*		
Vision				*		*	*	*			*		
Loneliness		*			*								
Isolation		*				*		*			*	*	
Social Support												*	
Nutrition				*									
Self care							*						
Dressing										*			
Shopping										*			
Cooking										*			
Hazards										*			
Medical history				*	*				*				

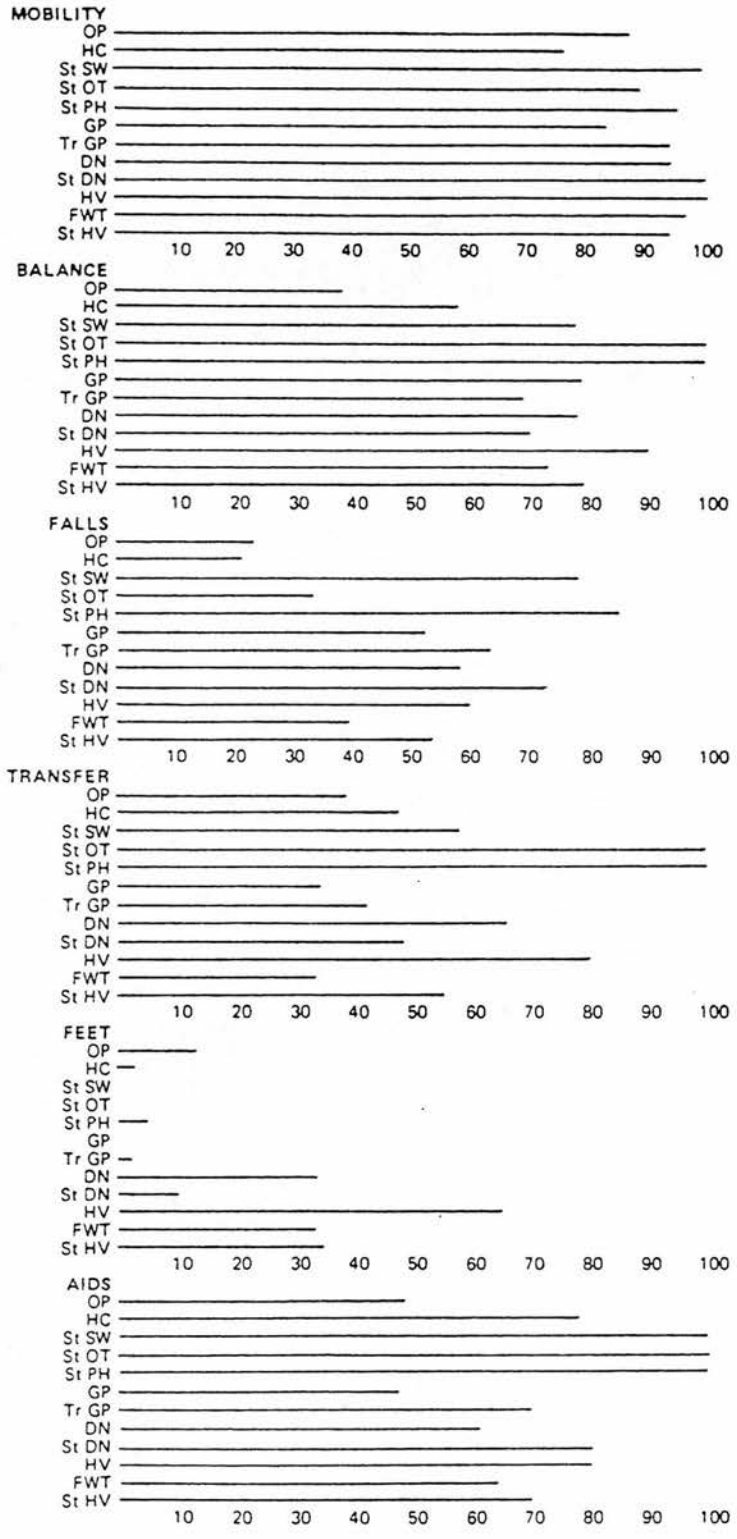

Figure 2.1 Percentage response of each group in mobility assessment categories. (OP= Old People)

RESPONSES TO QUESTION 3

This question asked participants to list the areas of assessment they would wish to have covered by the end of their interview.

The responses of the different professional groups were allocated to 46 categories as described above and then grouped under the following 11 headings.

1. Mobility

includes the categories:
- mobility
- balance
- falls
- transferring
- feet
- aids

The percentage response of each group, including the group of elderly people, in these categories is shown in figure 2.1.

As expected, almost all participants said that Mrs C's mobility should be assessed. In this area the OT and physiotherapy students scored highly and provided the greatest detail in all the categories except 'feet'. These two student groups used mobility as the starting point in assessment. By considering it in detail and by considering the consequences of impaired mobility, they were able to form links with other assessment categories.

Mrs C's difficulty with mobility was the key problem mentioned by most but surprisingly not all participants. Clearly related to the mobility problem were areas such as: balance, a history of falling and the risk of further falls, the use of her stick and furniture for support, the low chair and the potential hazard caused by the floor coverings.

Although there was much agreement and overlap between groups in the observations and problem listed, there were differences in detail which reflected particular professional perspectives. For example, the opening moments in which Mrs C tried to rise with difficulty from the

low chair was interpreted by a GP as a problem of arthritic hips and previously fractured femur, by a HV student as a problem of too low a chair, and by a physiotherapy student as a problem of leverage and poor hand function.

Responses were given in most categories by all groups but levels of agreement within groups varied. The HV student and FWT groups gave a wide range of responses and it was difficult to find any pattern or framework in the responses of these groups. In contrast, the social work students consistently commented about Mrs C's mood, her loss of relatives, her feelings and attitudes, the contact of her family and the support available from them. The occupational therapy students noted possible problems with dressing, shopping, cooking and home safety and physiotherapy students gave the most detail about balance, movement, the risks of falling, transferring from bed, chairs and toilet, hand function and grip strength. For example, the physiotherapy students wished to know the implications if the old lady fell. Would she be able to summon assistance? Was she isolated? Did she have a telephone?

Thus, these small groups of students had a clear focus for their assessment. A focus was less apparent for other groups and was least evident amongst the groups of health visitors.

Figure 2.1 shows the poor response regarding the assessment of possible problems with feet. The nurse groups, particularly the experienced health visitors, were the most aware of this area. Few, if any, in other groups mentioned problems with feet or foot care. The high prevalence of problems with feet and foot care in older people is well established. The failure of the participants to mention feet or foot care accords with the findings of Williamson et al (1964) and subsequent investigators that foot problems in the elderly remain unknown to the general practitioner.

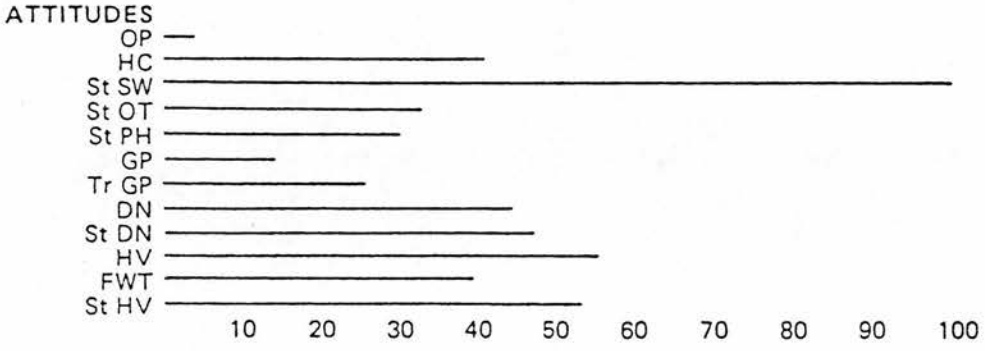

Figure 2.2 Percentage response of each group in attitudes assessment category.

2. Attitudes

The 100 per cent response for the social work group in this area of assessment represents only nine students. They differed from the other groups, however, by giving considerably more assessment detail in this area. For example, they listed several questions which might be asked such as 'How does she feel about the future?'. 'How does she feel about accepting help?'. 'How does she feel about the way she copes at present?'.

Few participants in other groups made any comment about the importance of knowing a patient or client's health beliefs and attitudes regarding the acceptance of advice or practical help and the success of treatment. Less than half of most groups and only one in seven of the experienced general practitioners mentioned the assessment of attitudes at all.

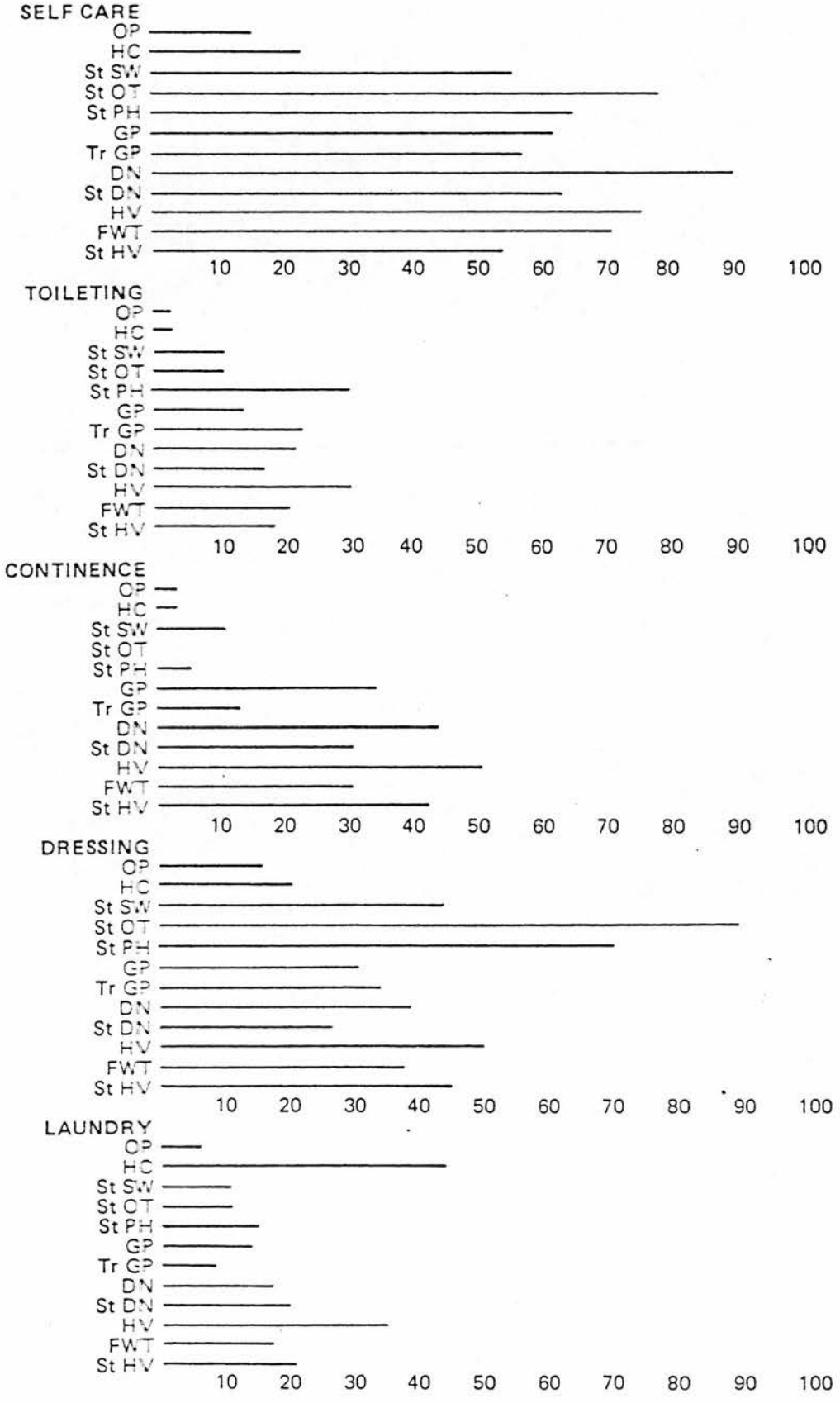

Figure 2.3 Percentage response of each group in self care assessment categories.

3. Self care

includes the categories:
- self care
- toileting
- continence
- dressing
- laundry

Figure 2.3 shows that over half the respondents in each group, except the home care organisers, mentioned the term self care itself. District nurses were most likely to describe this aspect of assessment. The extent to which detail was given in the various self care areas varied. The home care organisers' emphasis on laundry facilities and ability to was clothes was predictable. Similarly, the OT and physiotherapy students' emphasis on the ability to cope with dressing was understandable.

The low number of responses which specifically mentioned continence and toileting is surprising. The low response rates for the nurse groups in these two areas of assessment is of particular interest. Assessment of continence and helping elderly people with incontinence problems is regarded as nursing work yet, with the exception of the experienced health visitors, less than half of each nurse group recorded comments in this area.

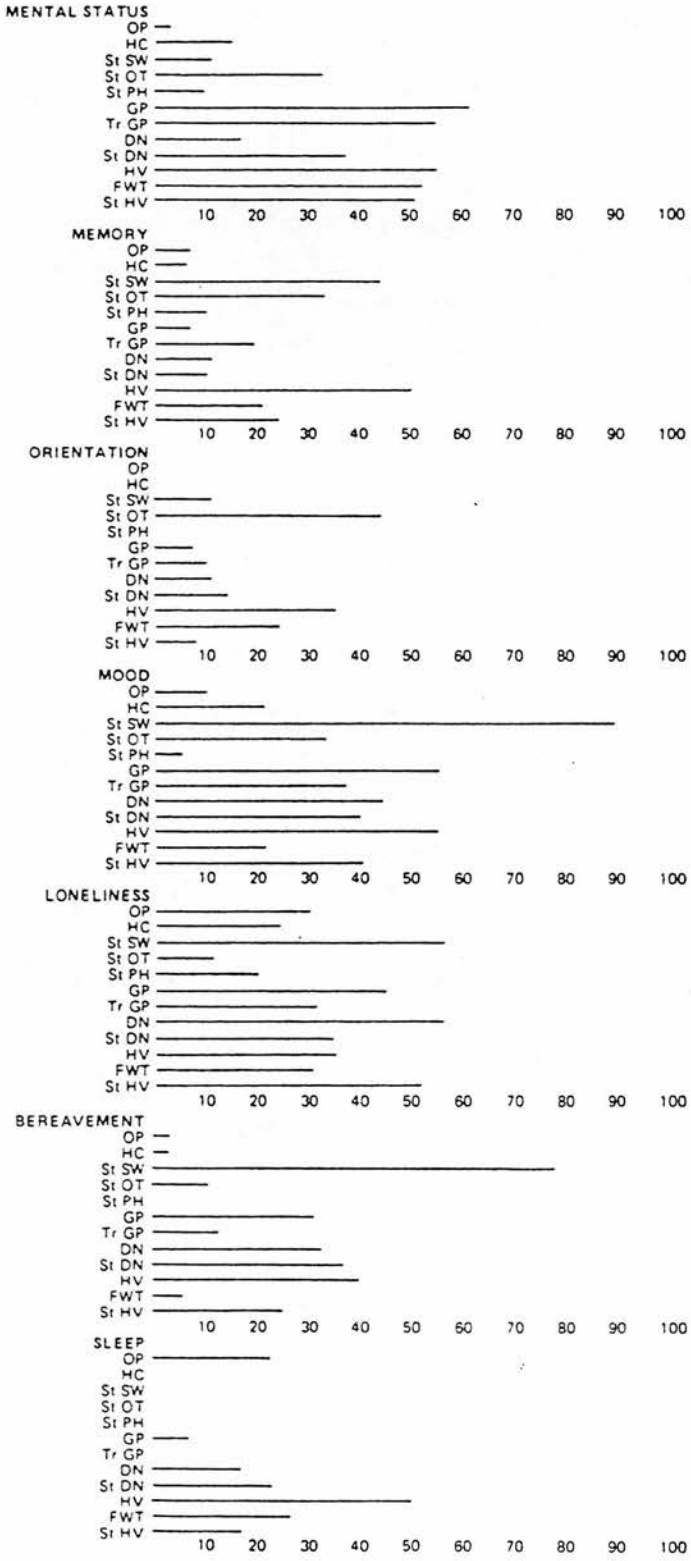

Figure 2.4 Percentage response of each group in mental state assessment categories

4. Mental state

includes the categories:
- mental status
- memory
- orientation
- mood
- loneliness
- bereavement
- sleep

From the high prevalence and serious implications of mental disorder in older people, the categories listed above should be high priority areas of assessment. Yet group responses in these areas were low and generally less than 50% (Figure 2.4). Several of the elderly participants wished the assessment of sleeping problems to be included in an assessment interview but only the nurse groups and a few GPs mentioned the assessment of sleep patterns. The other groups failed to identify this area of assessment at all.

The high level of responses by the social work students for mood and bereavement may be associated with their detailed comments regarding the assessment of Mrs C's feelings and attitudes.

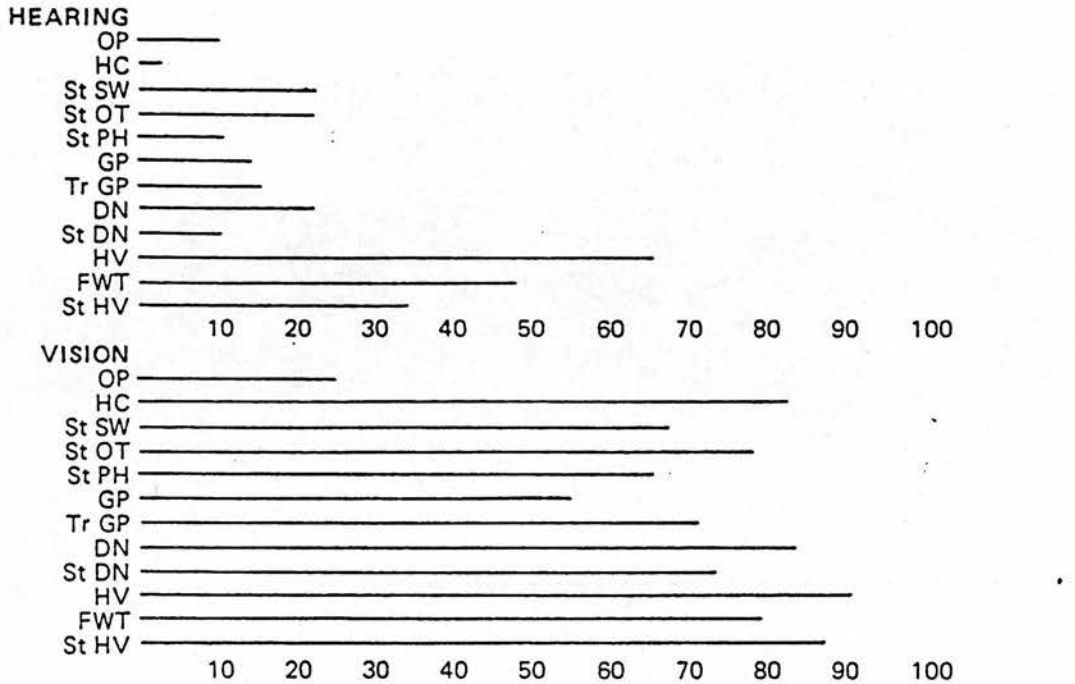

Figure 2.5 Percentage response of each group in hearing and vision assessment categories.

5. Special senses

includes the categories: vision
hearing

The high level of responses mentioning the assessment of vision (range: GPs 55% to experienced HVs 90%) were probably due to Mrs C talking of having poor sight in one eye in the recording.

It could have been expected that a similar proportion in each group would mention assessment of hearing, but the response rates were very low. With the exception of the HV groups, less than one quarter of the groups mentioned this category of assessment.

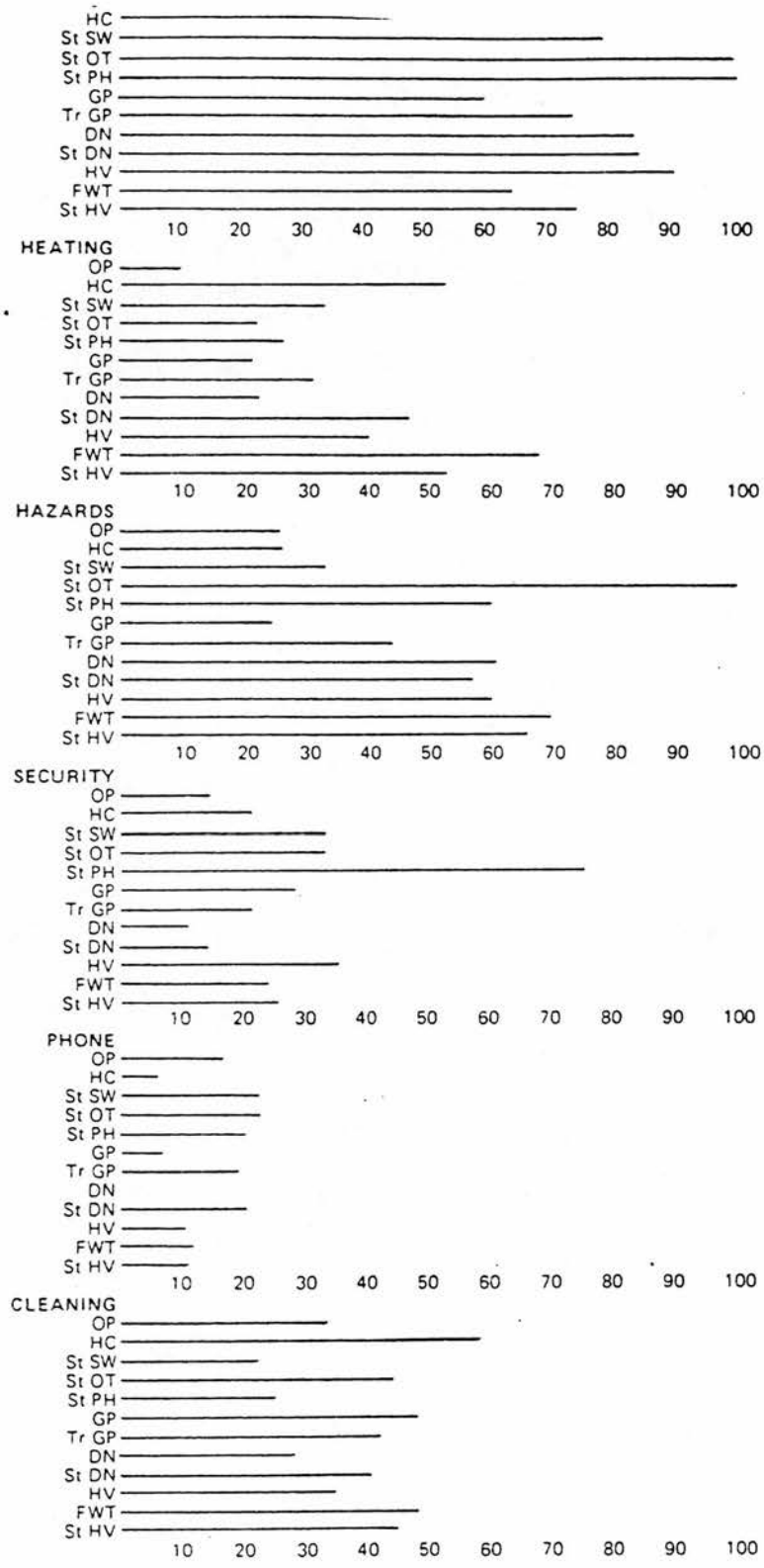

Figure 2.6 Percentage response of each group in house and household assessment categories.

6. House and household tasks

includes: house
heating
hazards
security
phone
cleaning

Assessment of the home was well detailed by all groups (Figure 2.6). Most respondents gave more than one item of assessment concerning the home environment and some gave as many as eight or nine.

Heating was most likely to be mentioned by the nurse groups and home care organisers. Assessment of potential hazards was detailed by all the OT students, by approximately 60 per cent of each of the nurse groups but by only a few of the GPs, social work students and home care organisers.

Assessment of security was not well recognised except by the physiotherapy students, who appeared to link this area of assessment to their assessment of an old person's history of falls, the security element being the possible inability to get help or to be unable to rise after falling. The most common comment was 'check what she can do if she falls'.

None of the experienced district nurses and few others mentioned assessment of access to and use of the telephone.

Assessment of household cleaning was highest predictably in the home care organiser group.

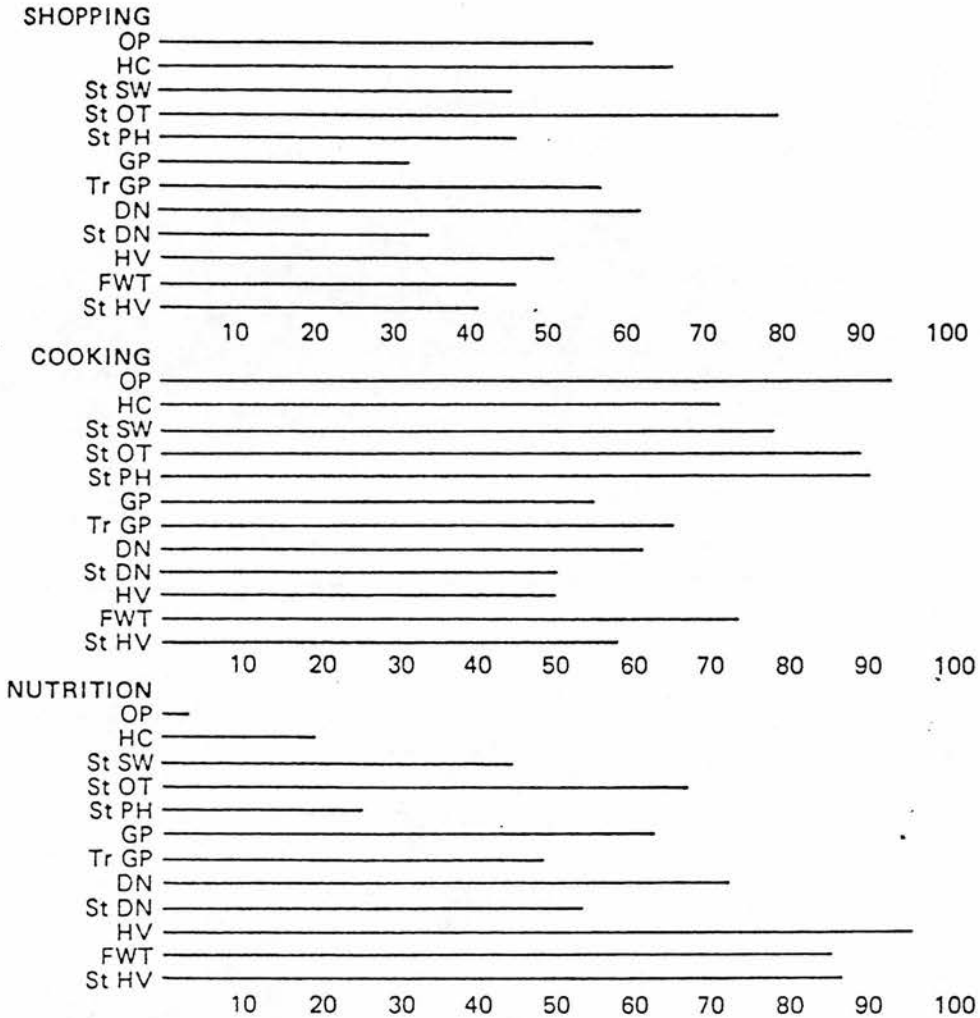

Figure 2.7 Percentage response of each group in food assessment categories.

7. Food

includes the categories: shopping
cooking
nutrition

References to cooking were more common than to shopping, with the OT and physiotherapy students providing most detail regarding ability to prepare and cook food.

The widest range of response in this section was in the assessment of nutrition, from 18 per cent of home care organisers to 95 per cent of experienced HVs. The HV groups, in particular, wished to assess in detail the content of the diet.

Results for assessment of teeth and dentures are not given as so few of the total sample mentioned this area.

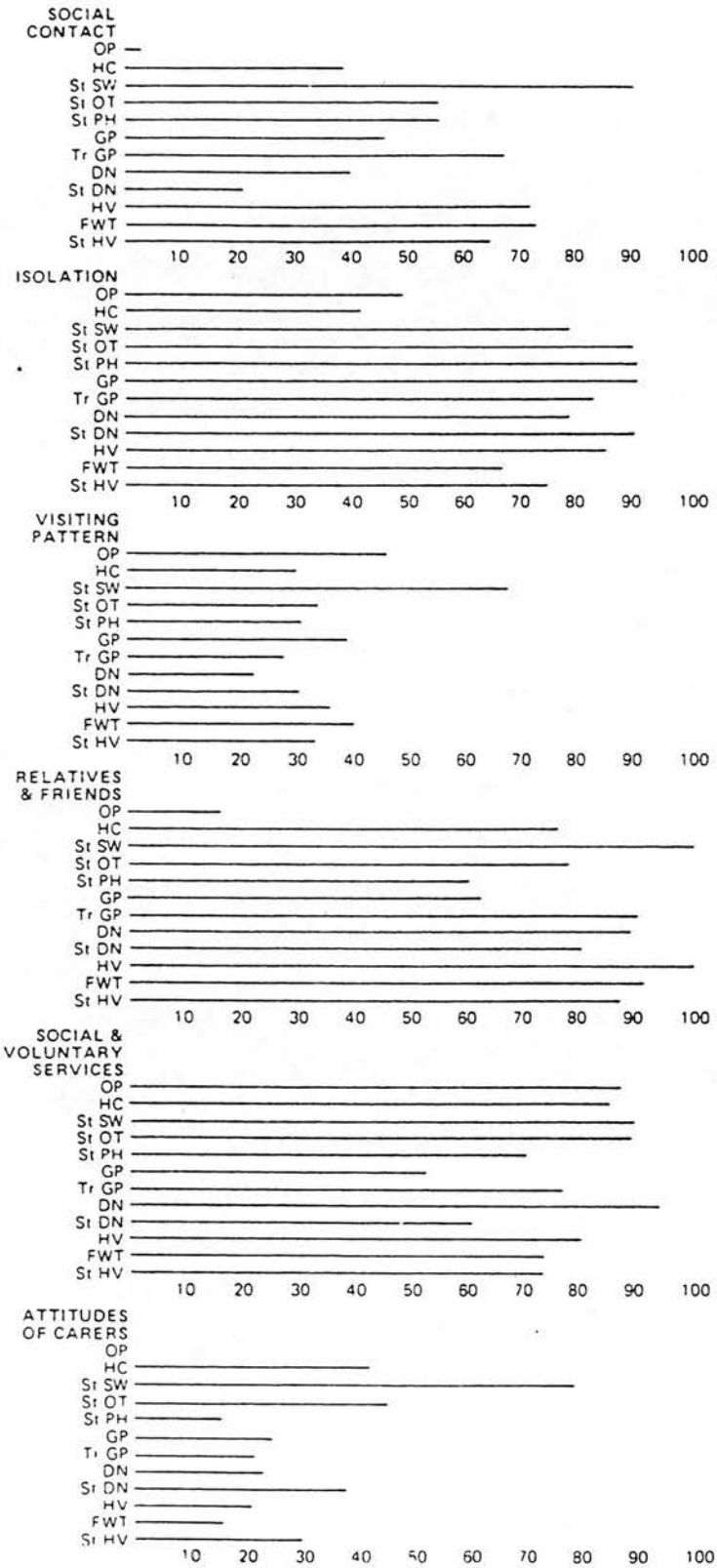

Figure 2.8 Percentage response of each group in social support assessment categories.

8. Social support

includes the categories:
- social contact
- isolation
- visiting pattern
- relatives and friends
- social and voluntary services
- attitudes of carers

The need for assessment of possible isolation and of contact with relatives, friends, social and voluntary services was noted by the majority (Figure 2.8). Assessment of the actual pattern of visiting by relatives and friends was less often mentioned. Few specifically questioned how near or far away they lived, how often they visited, or how many people visited.

Assessment of the attitudes of carers was least often noted. Those who mentioned the assessment of Mrs C's feeling and attitudes tended also to mention the attitudes of carers.

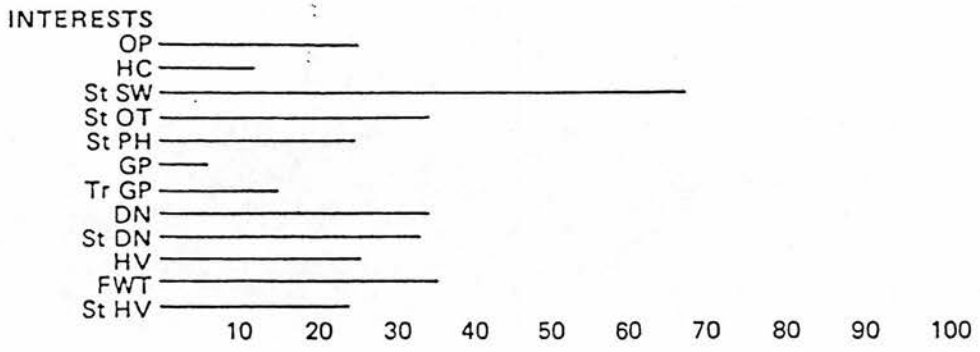

Figure 2.9 Percentage response of each group in interests assessment category.

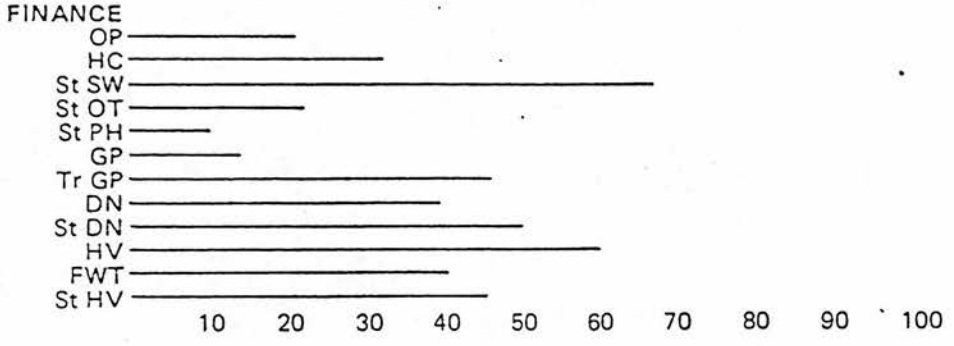

Figure 2.10 Percentage response of each group in finance assessment category.

9. Interests

Assessments of how an older person might spend her days and of interests and leisure activities was noted by few participants: by only 6 per cent of PGs and 12 per cent of home care organiser group. Six of the nine social work students outlined this area in detail.

10. Finance

Approximately half of the GP trainees and of the nurse groups and six of the nine social work students noted this area. It was less frequently mentioned by experienced GPs and by the OT and physiotherapy students.

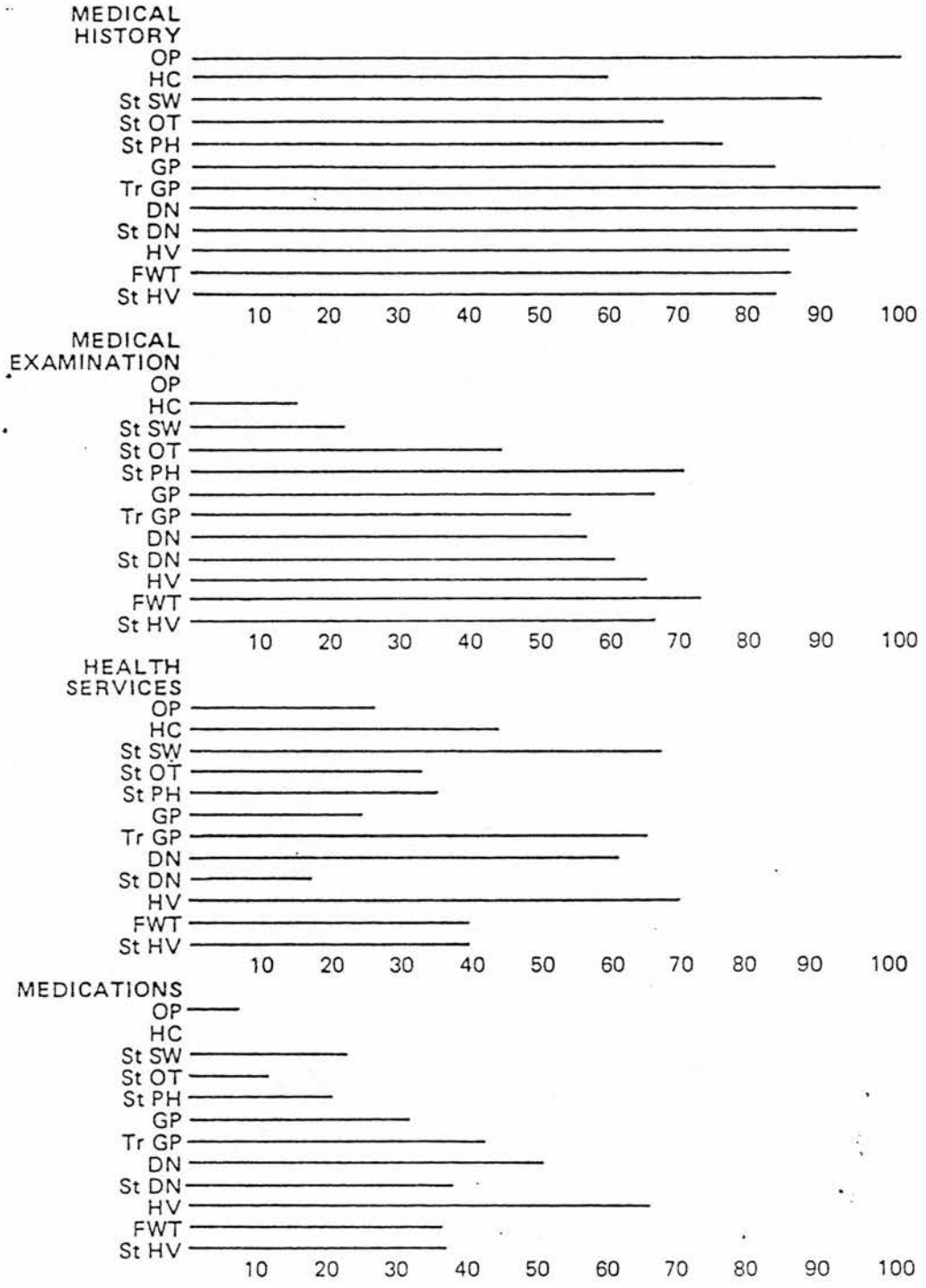

Figure 2.11 Percentage response of each group in health and medical support assessment categories.

11. Medical/health services

includes the categories: medical history
medical examination
health services
medications

A high proportion of all groups felt that a medical history should be included in an assessment and approximately half of each group, with the exception of social work students and home care organisers, suggested that some form of medical/physical examination should be carried out (Figure 2.11).

A few GPs mentioned 'screening' of such things as blood pressure, blood and urine and the GPs tended to suggest a systematic 'systems check', i.e. cardiovascular, locomotor, gastro-intestinal etc.

When answering these questions about the content of assessment, the participants did not know that the second video excerpt dealt with medication problems. The results for this category show therefore that, unprompted, only a small proportion of the groups included medications in their assessment framework. Apart from the 65 per cent figure for experienced HVs, approximately one third only of the other nurse and doctor groups mentioned this area and as few as 31 per cent of experienced GPs. The home care group of home care organisers did not mention medications in their assessments but some commented that they had a part to play in helping elderly people 'to take their drugs'.

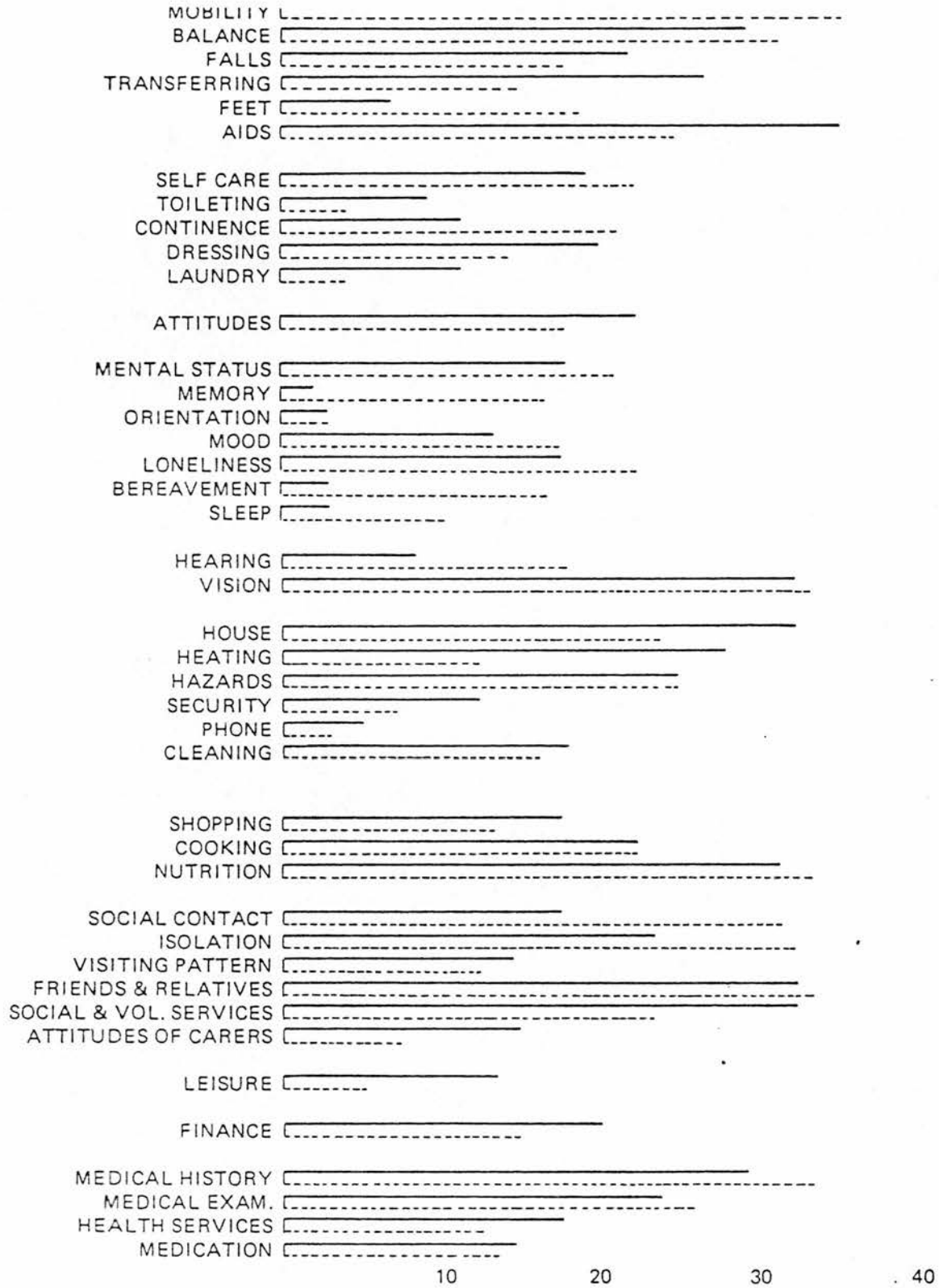

Figure 3 HV students (n=38) : number of students responding in each assessment category. Early —— and late------ in training.

HV STUDENTS: CONTENT OF ASSESSMENT EARLY AND LATE IN TRAINING

Thirty-eight of the HV students participated in the study twice, the second occasion being after a six month interval. In the interim they had received both fieldwork experience and classroom teaching about the elderly.

There were both increases and decreases for individuals in the numbers of responses in the different categories (Figure 3). Some of the initially high scoring categories improved further; mobility, balance, vision, nutrition, social contact, isolation, friends and relatives and medical history.

There was an increase in the number who mentioned assessment of feet but this remained only half of the group even on the second occasion. The lower number of responses for transferring and aids was interesting and might have been related to the students redefining of the roles and function of team members, with these areas of assessment being seen as more appropriate to OTs and physiotherapists.

In the self care category, there was a reduction after six months in responses mentioning toileting, dressing and laundry. The number of students mentioning continence rose from 11 to 21.

There was a reduction in responses indicating a wish to assess attitudes from 22 early to 18 students late in training. Although there was an increase in the responses mentioning mental status categories, the total response of the HV students remained low compared to other groups.

When subsequently questioned, the students could not account for the lower number of responses in the house and household task categories, with the exception of the fall in the numbers mentioning heating. The first set of responses had coincided with cold weather and could have focussed attention on the risks of hypothermia; the second set was obtained during the summer months.

DN STUDENTS: CONTENT OF ASSESSMENT EARLY AND LATE IN TRAINING

Fifteen district nurse students also participated twice in the study; providing information at the beginning and end of their six month training.

In seven areas there was a marked increase in the number of responses: continence, attitudes, memory, bereavement, sleep, finance and leisure. However, the overall number of responses was considerably lower on the second occasion. There was a loss of detail in the content of the assessments and the average number of scorable items dropped from 21 to 13 per student.

This reduction appeared to be related to a stereotyped way in which the questions were answered. On the second occasion, 12 of the 15 students adopted the same framework and answering style for their assessment using the categories:

physical
physiological
psychological
mental
emotional
safety
social
spiritual
financial

By adopting this standard framework of needs and problems as taught during their course, the answer of many students on the second occasion had lost some of the practical approach to assessment which had been evident at the start of the year. It was striking that the highest number of categories was mentioned by a student who did not adopt this theoretical need/problem framework.

VIEWS OF OLDER PEOPLE ABOUT THE SCOPE AND CONTENT OF ASSESSMENT

The method of obtaining responses from the two groups of older people who were attending day centres was the same as for other groups. Volunteers at the day centres assisted some of the older people to write the answers. All the 46 categories mentioned by health professionals were mentioned by at least one older person in each group, with the exception of assessments of orientation, dental care, and the attitude of supporters. This was achieved in spite of the number of responses per elderly person being low. For both groups of elderly people, the categories most frequently mentioned were mobility, medical problems, availability of social services and the ability to cook and shop. Loneliness and isolation were also frequently mentioned. It was noted that five out of each group of older people made some reference in their replies to their own circumstances. For example, one person mentioned her own bereavement and said how important it was for health visitors to be sensitive to possible grief. Another person thought that the old lady on the video-recording might fall as he had recently fallen himself.

The total range of assessment categories did appear to be very similar for older people and for health professionals. However, the range and content of assessment differed considerably between older people. Some elderly people saw assessment purely in physical terms whereas others were much more concerned with social and emotional problems.

VIDEO STUDY - MRS C

SUMMARY OF RESPONSES TO QUESTIONS 1 - 3

QUESTIONS 1 AND 2

1. On the basis of a video stimulus lasting only 3½ minutes, many observations were made and numerous actual or potential health problems were identified.

2. The elderly woman who was interviewed on the video-recording was perceived in different and sometimes opposing ways.

3. There was good within and between group agreement for half the problem and observation categories identified, but there were differences in the detailed descriptions of problems which reflected different professional perspectives.

QUESTION 3

1. It was possible to classify the responses of participants into 46 major categories of assessment.

2. Within many categories, some individuals were able to give very detailed responses and many items of assessment.

3. The focus and starting point of assessment differed between groups. For example, social work students focussed on the feelings and attitudes of the old person and her helpers; physiotherapy and OT students focussed on mobility related areas. A focus was less apparent for other groups and least evident among health visitors.

4. The following areas of assessment were infrequently mentioned:

feet	attitudes and feelings of helpers
continence	medication
toileting	memory and orientation
hearing	bereavement and sleep
security and telephone	teeth and dentures

5. The assessment categories put forward by HV and DN students early and late in training changed in a complex way. For the HV students, there were higher numbers of responses in some areas and fewer responses in others. The overall response of the DN students was lower on the second occasion, and appeared to be due to the adoption of a theoretical framework of assessment which had been taught during their course.

6. The range of assessment categories was very similar for older people and for health professionals. Forty-three of the 46 categories derived from the responses of the health professionals were mentioned by at least one of the 31 elderly people.

VIDEO STUDY - MRS C

QUESTIONS 4 - 8

The purpose of the questions was to meet aim 3 by building up a profile of the role of each professional group in the continuing care of this elderly person as perceived by themselves and by others.

Mrs C wishes to stay in her flat. She does not wish to have a home help. Ner niece says she can visit daily. She is discussed at the practice team meeting.

Should she have regular visits ? **YES/NO**

If NO - Why not?

If YES - Who will visit?

For what reasons?

How frequent should visits be?

Should Mrs C. be visited?

Almost all participants thought that Mrs C should have regular home visits (Table V).

Table V. Mrs C - Question 4. Number in each group indicating that Mrs C should/not be visited regularly

Group	Should be visited	Should not be visited
HV students (early)	42	1
HV students (late)	35	3
FWTs	33	-
HVs	20	-
DN students (early)	22	2
DN students (late)	15	-
DNs	16	3
GP trainees	44	5
GPs	25	4
OT students	9	-
PH students	20	-
SW students	8	1
Home care	31	3

Of the 22 who answered 'No' most said 'The niece should report any problems needing attention provided she is met and the matter discussed'. Getting to know the niece, offering advice about care and sources of help, encouraging independence and being available by telephone were the main criteria for selecting a policy of not visiting regularly.

Despite the high level of agreement about the need for regular visits, there were considerable variations in the reasons given for visiting and in the suggested frequencies.

Who should visit?

Many participants selected more than one profession for visiting and comments were made about the desirability of negotiating with other professionals to decide a plan of visiting and a system for review. There were indications in some responses of past difficulties in team relationships and organisation. A general practitioner remarked 'ideally the GP and HV should liaise and not both call on the same day!' and a home care organiser commented 'the old lady must know and agree to these agencies before they descend on her'.

Overall, the health visitor was mentioned most frequently, followed by the district nurse and general practitioner. Each group tended to nominate itself as the main visitor.

The social work and physiotherapy students were seldom mentioned by other groups but these groups nominated themselves to visit. Eight of the 20 physiotherapy students included the OT as a possible visitor, but the nine OT students did not mention the physiotherapist. Also, despite the statement that Mrs C did not wish to have a home help at the time, four home care organisers said that they would still like to visit her. They felt, from experience, that an old person 'could come round to the idea of a home help' and a visit might lead to the idea 'being acceptable in the future'.

The other visitors who were suggested included meals on wheels personnel,

chiropodists, HV and DN assistants, bath attendants, Welfare for the Blind, ministers and church visitors, unspecified voluntary organisations, and someone to provide a 'tucking down' service.

Frequency of visits

It was suggested that Mrs C be visited from as often as daily to as infrequently as six monthly. Not all participants were prepared to state a frequency. The range and modal frequencies of proposed visiting patterns were noted for health visitors, district nurses and general practitioners. As expected, there were differences between and within the professional groups. The modal frequency of visiting was used to make simple comparisons between the groups.

For visits by health visitors, fieldwork teachers most often selected three monthly visiting, the other experienced health visitors selected monthly contact. HV students early in training suggested even more frequent contact than once per month but later in training had moved towards the pattern of the experienced practitioners: of the 23 HV students early and late in training who suggested a frequency of visits, 21 changed to suggesting visiting less often and two remained unchanged.

There was a very wide range in the suggested frequency of visits by a health visitor proposed by individuals in the other professional groups: from twice weekly to three monthly. Monthly visiting was the most common suggestion, an expectation which is in conflict with the view of fieldwork teachers but in agreement with the majority of the other health visitor groups.

The district nurses were expected by others and by themselves to visit more frequently than health visitors. The DN students generally suggested weekly visits and several proposed a daily contact. The experienced district nurses suggested visiting less often than the students proposed.

Fewer participants gave a frequency for proposed visits by a general practitioner. Monthly contact was the frequency most often suggested

with a range from weekly to six monthly. A frequency of visits was seldom suggested for the other groups.

Purpose of visits and perception of roles

The reasons given for proposing regular visits to Mrs C were varied. Many comments, particularly from the student groups, were vague; 'visiting to stay in touch', 'to see how she is managing', 'to see all is well', 'routine visiting as required'.

Few specific tasks were mentioned except for district nurses who were expected by members of all groups, including themselves, to bath Mrs C. Similarly, the occupational therapists, if mentioned at all, were expected to provide aids.

1. Health Visitors

The most frequently mentioned reasons for visits by a health visitor were: general assessment of needs, problems and ability to cope; assessment for and referral to services; checking for deterioration; and supporting Mrs C and her niece.

The home care organisers' perspective was slightly different. They suggested that the health visitor should 'check if the niece was still being supportive' and 'assess if Mrs C's attitude to home care was changing'.

Health visitors themselves added the following reasons:

Assessing social circumstances
Assessing acceptance of help
Checking medication
Screening
Monitoring
Supervising
Providing surveillance
Detecting problems early
Preventive work
Providing health education
Counselling
Advising
Encouraging and helping maintain independence

Discussing problems with client and carers
Reassuring
Providing friendly contact
Establishing relationships
Reporting to GP
Referral
Liaising with health team, carers and other agencies
Co-ordinating

2. District Nurses

All groups expected the district nurse to visit Mrs C in order to help her bath. Eleven of the experienced district nurses agreed but a few remarked that, rather than assume a need for help, they would first assess whether Mrs C wished help with personal hygiene.

The district nurse students suggested a much wider range of activities for themselves and by the end of their six month course had become less vague about reasons for visiting. Bathing and 'general nursing care' remained the most frequently mentioned reasons, but late in training the following were added:

Assessment of physical, emotional and social needs
Assessment of medications
Assessment of home environment
Assessment of fears and worries
Assessment of views about accepting help
Supporting niece and carers
Teaching carers
Advising about diet
Encouraging independence
Rehabilitation
Arranging aids
Referral to other services
Providing stimulation
Providing social contact
Preventing isolation
Maintinaing well-being
Encouraging outings and social contact
Forming a relationship

This range of reasons is similar to the health visitor list and it indicates considerable overlap in roles, at least as perceived by district nurse students.

A few experienced district nurses interpreted Mrs C's circumstances differently. They felt that 'no basic nursing care' or 'nursing

procedure' would be required; visiting would therefore be 'supervisory only' and 'more the HV's role'. Similarly, a few health visitors remarked that 'if no nursing was needed' or if there was 'no nursing problem' they would visit rather than the district nurse.

The stereotype of the district nurse as someone who baths patients and the much wider view of their role as perceived by some of the district nurse students will be discussed in Part III of the thesis.

3. General Practitioners

There were few detailed reasons offered about the purpose of a regular visit by a general practitioner. Other groups most often mentioned a general health check and medical assessment/examination with the checking of drugs and the assessment of the effects of treatment.

The general practitioners suggested a wider role for themselves and mentioned activities which also appear in the district nurse and health visitor lists. Consequently overlap in function between these three groups is considerable:

Screening
Early detection
Assessing progress or deterioration
Identifying problems
Discussing needs
Reassuring
Supporting
Referral
Maintaining contact
Liaising with HV and others

Some of the comments made by the general practitioners about the work of their colleagues might have been challenged at the practice team meeting which some participants proposed: for example, 'the HV is more likely to be told "little problems"'. The comment from a general practitioner that 'the DN or HV should visit two or three times a week to help her to wash' would probably have created lively debate.

4. Occupational Therapy, Physiotherapy and Social Work students

Whereas all other groups tended to see the OT as a 'provider of aids' only three of the OT students mentioned this as part of their work. Assessment, advice about work methods and aids, support and follow up were given as their professional contribution.

Comments from physiotherapy students tended to be clear and precise about the purpose of their visits:

Improve balance
Improve walking
Improve transfers
Advise on functional difficulties
Increase range of movement in lower limbs
Re-education about balance
Ensure she can get off floor if she falls
Heat treatment if in pain with arthritis
Strengthen lower limb muscles

One physiotherapy student suggested a combined occupational therapy and physiotherapy visit 'to ensure that the home is of a standard to allow the patient to remain there safely'.

The social work students saw exploring attitudes and relationships, providing emotional support and assessing the need for help, sheltered housing and holidays in their reasons for visiting. One student remarked that the social worker would 'do the same as the HV but the social worker has the advantage of being able to build up a relationship'; building up relationships was also mentioned by several health visitors as an important part of their work.

Another social work student stated 'I do not know much about the HV's role. I tend to view them more as medics; and the GPs are too busy!'.

VIDEO STUDY - MRS C

SUMMARY OF RESPONSES TO QUESTIONS 4 - 8

1. There was a general feeling that an elderly disabled lady such as Mrs C who has recently fallen and who lives alone should be visited on a regular basis by a member of the primary health care team.

2. Health visitors were the group most often suggested for this task but all groups felt that they have a contribution to make.

3. Students expected visits to be more frequent than experienced workers and there was evidence that HV students modify their views about the frequency of visits towards those of experienced health visitors.

4. There is considerable overlap of functions judged by low the different professional groups perceived their own roles.

5. The perception of the role of another profession was much narrower than the perception by health professionals of their own role.

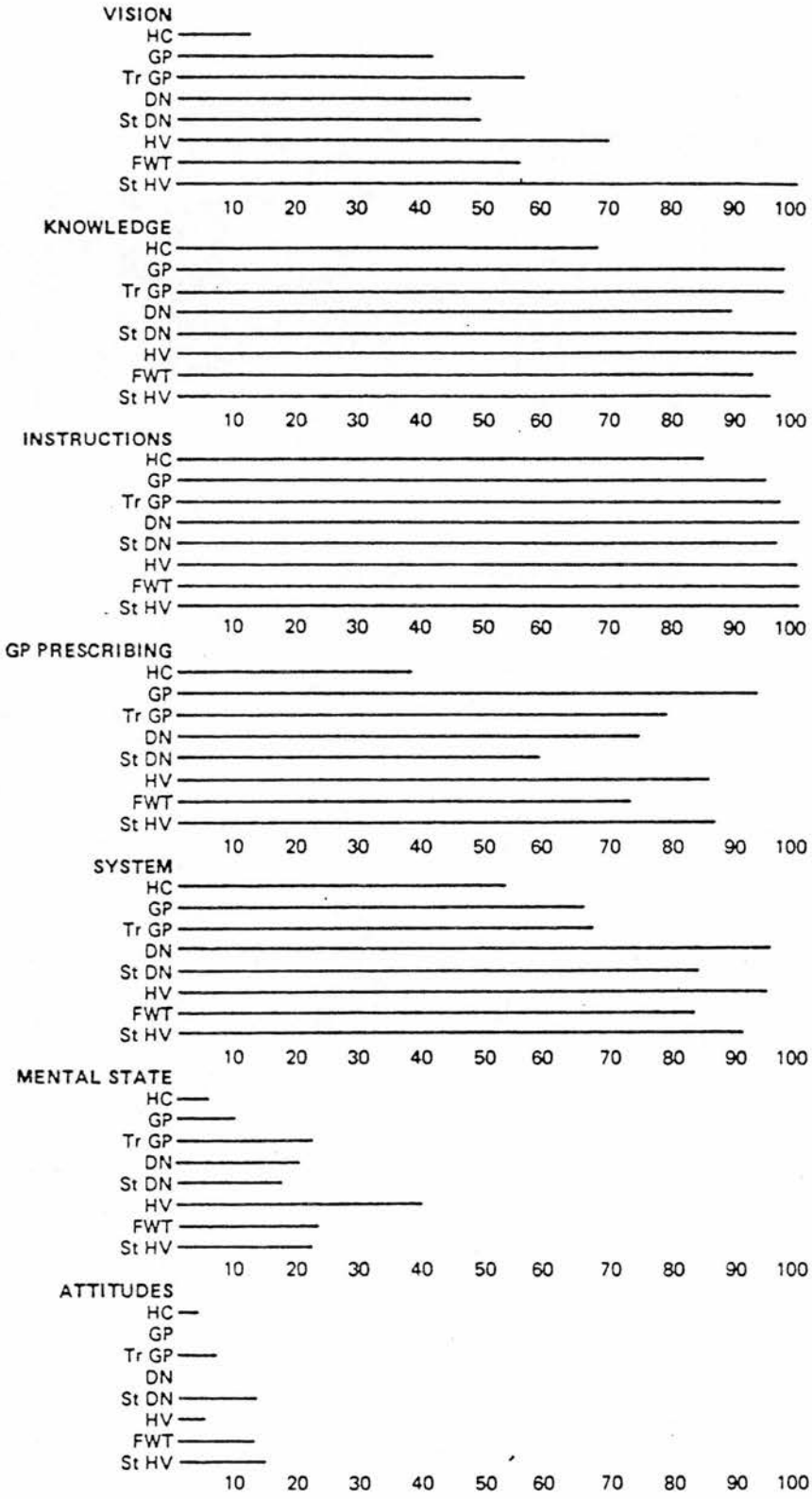

Figure 4 Mrs. W. Medicine taking problems and action. Percentage response of each group in each category to questions 1and 3.

VIDEO EXCERPT 2 - MEDICINE TAKING - MRS W

The method of analysis for the medicine taking questions was similar to that used in video excerpt 1. The responses of the health visitor students in the pilot study were used to construct a scoring schedule. The responses of the other groups were allocated to the categories of the scoring schedule by the two investigators independently. The number of categories was much smaller than in the analysis of the first excerpt and discrepancies between the two investigators were negligible.

Mrs W demonstrated several common problems of medicine taking. For example, she had difficulty seeing and reading the labels on the bottles of tablets. She did not know what each medicine was for. There were discrepancies between the instructions on the labels, the instructions on a written list and what she said she was taking each day.

Questions 1 and 3 - Problems observed and action taken

Question 1 and Question 3 generated very similar responses and were analysed together. Instead of identifying problems, many participants suggested action as a response to Question 1 and then repeated their recommendations in Question 3. This was particularly true for the group of experienced district nurses, who as a response to Question 1 made comments such as 'Could home helps supervise the drugs?', 'Containers labelled - breakfast time tablets - would help'.

Figure 4 shows the different categories of response to these two questions. The home care organisers made fewer responses than the other groups. The experienced general practitioners were most likely to question the actual drug regime portrayed in the excerpt and were also most likely to expect the health visitor to discuss the regime with the general practitioner concerned. Other groups sought to clarify rather than challenge the drug regime prescribed by the doctor.

Differences between the professional groups were apparent when the system of medicine taking was considered. The two groups of general practitioners mentioned the lack of a system as a problem and made their comments as responses to Question 1. In contrast, the health visitors and district nurses made more comments in this area in response to Question 3. Groups of experienced health visitors and district nurses were almost unanimous in making practical suggestions about the way in which a daily supply of medications could be laid out and how this system could be supervised. The flavour of the responses from the health visitor students indicated that, once instituted, any system of medicine taking would need to be tested and checked up on. The desire to test abilities was also evident in the student health visitors' comments about the elderly lady's understanding and knowledge about the different prescribed medicines. As well as wishing to teach and explain about the purpose and action of the different medicines, several students specifically mentioned that they would test the old lady's understanding.

Only one in five of the participants made any comment about the lady's memory or mental state. Comments such as 'dogmatic', 'set ideas, difficult to change' may have revealed the attitude of the observer more than that of the elderly lady. One in five of the participants made comments which were not categorised and they were a miscellany ranging from suggestions of deafness to speculation about sleep problems and risks associated with the storage of medicine bottles.

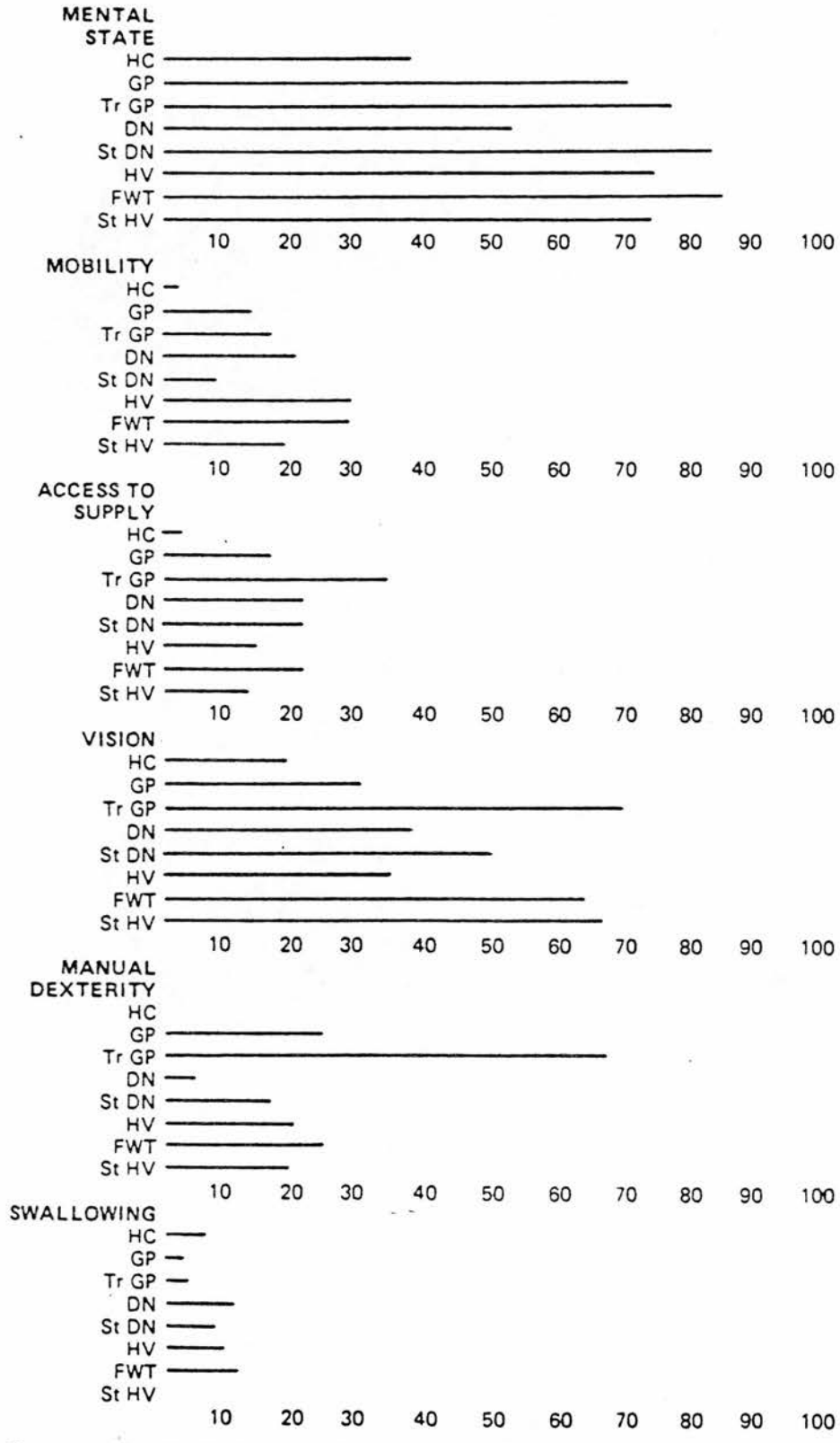

Figure 5.1 Mrs. W. Medicine taking - assessment. Percentage response of each group in six categories to question 2.

The pattern in Table VI shows that there was broad agreement about the problems identified and the appropriate action which was suggested.

Table VI Mrs W - Medicine taking. Questions 1 and 3
Categories in which half or more of each group responded

	HV St	FWT	HV	DN St	DN	GP Tr	GP	HC
Vision	*	*	*	*		*		
Knowledge and understanding	*	*	*	*	*	*	*	*
Instructions	*	*	*	*	*	*	*	*
GP prescribing	*	*	*	*	*	*	*	
System	*	*	*	*	*	*	*	*
Mental state								
Attitudes								

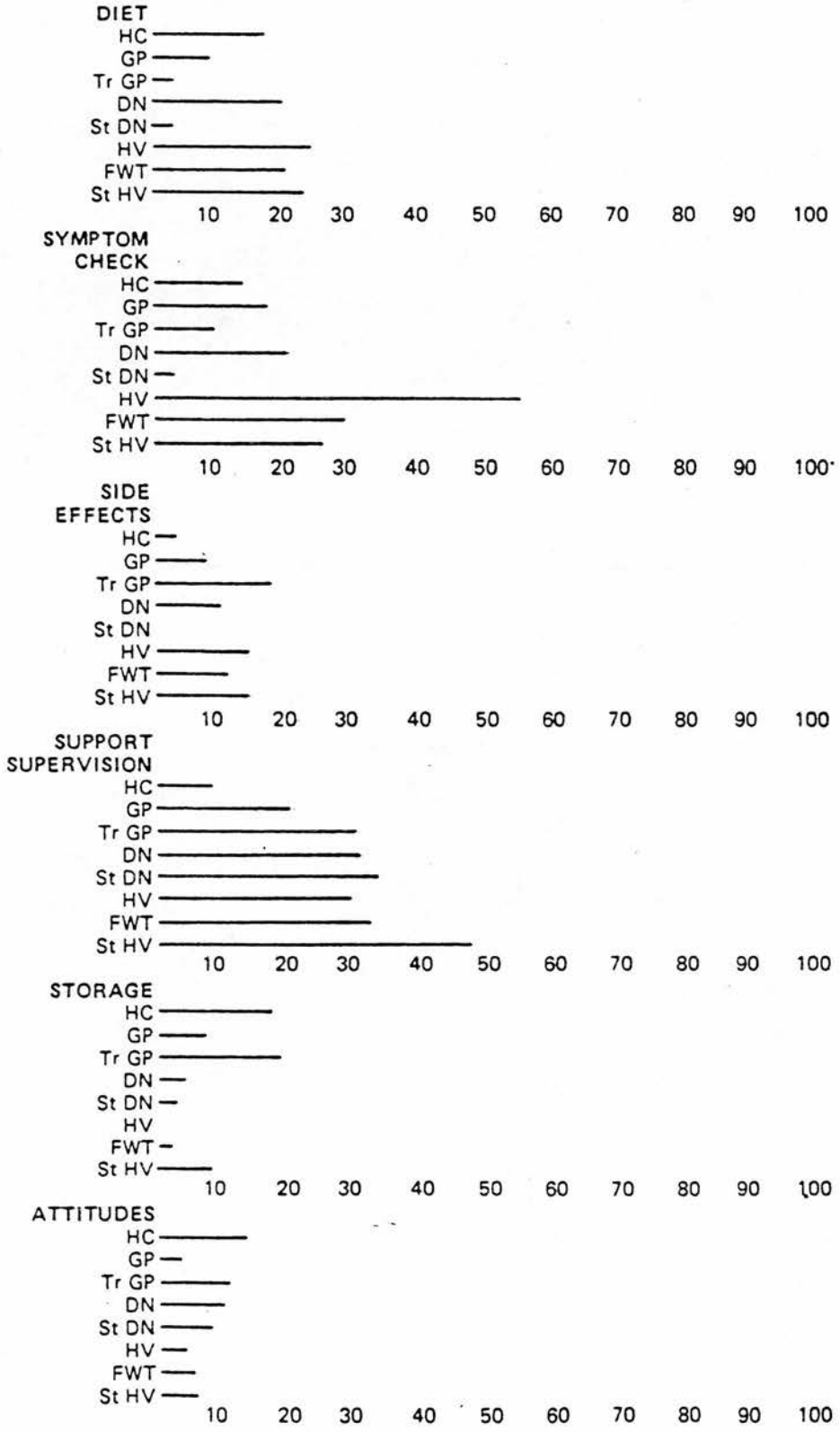

Figure 5.2 Mrs. W. Medicine taking assessment. Percentage response of each group in six categories to question 2.

Question 2 - Relevant health visitor assessment

In contrast to the responses to Questions 1 and 3, the main impression gained from Figures 5.1 and 5.2 and Table VII is the lack of agreement and structure in the way answers were recorded. No clear pattern emerged. The overall response rate was low ranging from two categories per person for the home care organisers to four for the groups of trainee general practitioners and fieldwork teachers. The replies jumped from one category to another without any logical or coherent progression. There was a wide range of responses but only low scoring in any one particular category. The assessment of mental state was the only category in which more than half the participants made a comment.

Table VII Mrs W - Medicine taking. Question 2.
Assessment categories in which half or more of each group responded

	HV St	FWT	HV	DN St	DN	GP Tr	GP	HC
Mental state	*	*	*	*	*	*	*	
Mobility								
Access to supply								
Vision	*	*		*		*		
Manual dexterity						*		
Swallowing								
Diet								
Symptom check			*					
Side effects								
Non-prescribed medicines								
Support and supervision								
Storage								
House								
Attitudes								

There did not appear to be any major difference between the responses of the health visitor groups compared with the responses of the other groups. One minor area of difference was that health visitors were most likely to consider a symptom check as an appropriate area of assessment.

Only three of those participating in this part of the study made a comment about non-prescribed medications. Only one in ten mentioned the attitude of the elderly person as an appropriate area of assessment. Although the total number of comments made by the home care organisers was very low, this was one category where they had a higher percentage response than the other groups. The other category where they scored more highly than other groups was in considering the storage of medicines.

As in the responses to Questions 1 and 3 there was a miscellary of comments which were not separately categorised and included comments about hearing, sleep, medical history and assessment of the activities of daily living.

SUMMARY

1. There is currently increasing concern about medicine taking in elderly people and growing awareness of the factors influencing compliance (Parish et al, 1983).
2. There was broad agreement amongst the groups participating in this part of the study about the problems demonstrated by Mrs W and about action which could be taken.
3. All groups had difficulty outlining the content of a health visitor's assessment of medicine taking. No clear framework of assessment emerged and there were major gaps in assessment affecting all groups.
4. A need for specific training for health professionals in assessment of medicine taking in older people is suggested.

ATTITUDES TO WORKING WITH OLDER PEOPLE

METHODS

It was decided to approach the assessment of feelings and attitudes to older people in two different and complementary ways.

First, respondents were asked for decriptions, in open-ended questions, of their feelings about working with older people at home and of previous experiences which might have influenced them in their views (Appendix IV). The intention was not to make any measurement of attitude but to elicit a response from which it might be possible to draw common themes. Each respondent would be using their own perception of what work with older people implied. It was recognised that comparisons between the feelings of particular groups of professionals would be difficult and subjective.

SEMANTIC DIFFERENTIAL

The second more objective approach was chosen to contrast with the first diffuse method. A semantic differential was designed for use with a third video excerpt. This excerpt was a 30 second passage which showed another elderly lady who demonstrated difficulties in descending a flight of stairs. This excerpt was used as the standard stimulus for the semantic differential.

The semantic differential is a technique devised by Osgood et al (1957) and has been used in the measurement of attitudes of nurses and other primary health care workers (Ellis 1982, Reedy et al 1983).

The technique asks for responses in the form of an 'X' on a seven point scale between adjective pairs appropriate for the concept being evaluated. The eleven adjective pairs were selected from the responses of the health visitor students to direct questions about feelings towards the elderly. The list includes pairs such as warm/cold, active/passive, influential/uninfluential. The appropriateness of the adjectives selected was also tested by reference to previous work by Osgood et al (1957) to gauge whether they had been effective in other settings in gauging the components of meaning described as 'evaluative', 'potency' and 'activity'. Rank order of adjective pairs and polarity were allocated in a random fashion.

The particular video excerpt for this part of the study was selected because it portrayed a real elderly lady in a real situation with a problem that was likely to be familiar and relevant to the professional role of the participants. There were no unusual features or redundant information shown about the lady which would distort the responses. The technique proved to be easy to apply and very acceptable to the participants, possibly because it had been constructed specifically for the purpose of the research and appeared to be highly relevant and because of its speed in use, approximately five minutes. The responses to the semantic differential question are reported first because they concern general attitudes and feelings. The responses to the questionnaire indicate more specific themes which may be responsible for these feelings.

The adjective pairs were selected with care. All except one pair produced responses which approximated to a normal distribution. The quick/slow pair generated a very wide range of scores. The reason that the quick/slow pair produced a neutral overall response with a wide range of individual scores may be that some participants considered 'slow' to be a positive attribute, whereas in most situations 'quick' is associated with positive feelings. This emphasises that descriptions of feelings need to be interpreted only in a defined context and even then with extreme caution.

As a test of the validity of the scores, the procedure was repeated with a group of general practitioner trainees after a period of half an hour. This was a different group of trainees from those analysed in the rest of the study. The results showed that there was good reproducibility of the responses compared with previous studies using this technique. Only 4.8 per cent of responses for each adjective pair differed by more than two scale units and this is a similar result to those in previous studies using larger numbers (Osgood et al, 1957). Changes of one scale unit were common and occurred in both directions so that the change in the mean overall score was negligible (0.005). Changes were distributed evenly throughout the test.

The validity of the scores in the test is also supported by the overall consistency in the rank order of the adjective pairs for the different groups (Kendall's co-efficient of concordance W = 0.646 X^2 = 710.6 significant at p 0.001 level). A similar consistency was shown by the group of health visitor students who were tested at the beginning and at the end of their year's course.

The overall response in this test was positive in that the mean score for the whole group was 53.5. A neutral response would have been 44 with the most positive score possible 77 and the most negative 11. The overall pattern of responses are shown in Table VIII. Tables IX - XI show the rank order of the adjective pairs for each group of participants.

Table VIII Semantic differential - means and rank order of adjective pairs

	Mean	
Bored	5.9	Interested
Cold	5.6	Warm
Reluctant	5.1	Eager
Useless	5.0	Useful
Disorganised	4.9	Organised
Pessimistic	4.7	Optimistic
Tense	4.68	Relaxed
Uninfluential	4.55	Influential
Vague	4.55	Precise
Passive	4.5	Active
Slow	4.0	Quick

Neutral = 4 Range 1 to 7

Table IX Semantic differential Rank order of adjective pairs (showing positive adjective only) for the social work, occupational therapy, physiotherapy and home care groups

Rank Order	Student SWs	Student OTs	Student PHs	Home Care Organisers
1	Warm	Interested	Interested	Interested
2	Interested	Useful	Warm and Relaxed	Warm
3	Eager	Organised		Organised
4	Optimistic	Optimistic, Warm and Precise	Eager	Eager
5	Quick		Influential and Active	Useful
6	Active and Influential			Precise
7		Influential and Active	Useful	Active
8	Useful		Organised	Optimistic
9	Organised	Eager	Optimistic	Influential
10	Relaxed	Relaxed	Precise	Quick
11	Precise°	Quick	Quick	Relaxed

* Mean score of group 2 Standard Errors above mean score of all respondents for the particular adjective pair

° Mean score of group 2 Standard Errors below mean score of all respondents for the particular adjective pair

Table X Semantic differential Rank order of adjective pairs (showing positive adjective only) for the district nurse and general practitioner groups

Rank Order	Student DNs	Experienced DNs	Trainee GPs	Experienced GPs
1	Interested	Interested*	Warm	Interested
2	Warm	Eager	Interested°	Warm
3	Useful	Useful	Relaxed	Useful
4	Relaxed	Warm	Organised	Influential
5	Eager	Optimistic	Eager°	Eager°
6	Optimistic*	Organised	Useful°	Optimistic
7	Organised	Precise	Influential	Organised
8	Precise	Active	Active	Relaxed
9	Influential	Influential	Quick	Active
10	Quick	Relaxed	Optimistic°	Precise
11	Active	Quick	Precise°	Quick

* Mean score of group 2 Standard Errors above mean score of all respondents for the particular adjective pair

° Mean score of group 2 Standard Errors below mean score of all respondents for the particular adjective pair

Table XI Semantic differential Rank order of adjective pairs (showing positive adjective only) for whole sample and for the health visiting groups

Rank Order	Whole sample	Student HVs	Experienced HVs	Fieldwork Teachers
1	Interested	Interested*	Interested*	Interested
2	Warm	Warm*	Warm	Warm
3	Eager	Eager*	Eager	Useful
4	Useful	Useful	Optimistic	Eager
5	Organised	Active*	Useful	Organised
6	Optimistic	Organised	Precise	Relaxed
7	Relaxed	Relaxed	Influential	Precise and Optimistic
8	Precise and Influential	Optimistic	Active	
9		Influential	Organised	Influential
10	Active	Precise	Relaxed	Active
11	Quick	Quick	Quick	Quick

* Mean score of group 2 Standard Errors above mean score of all respondents for the particular adjective pair

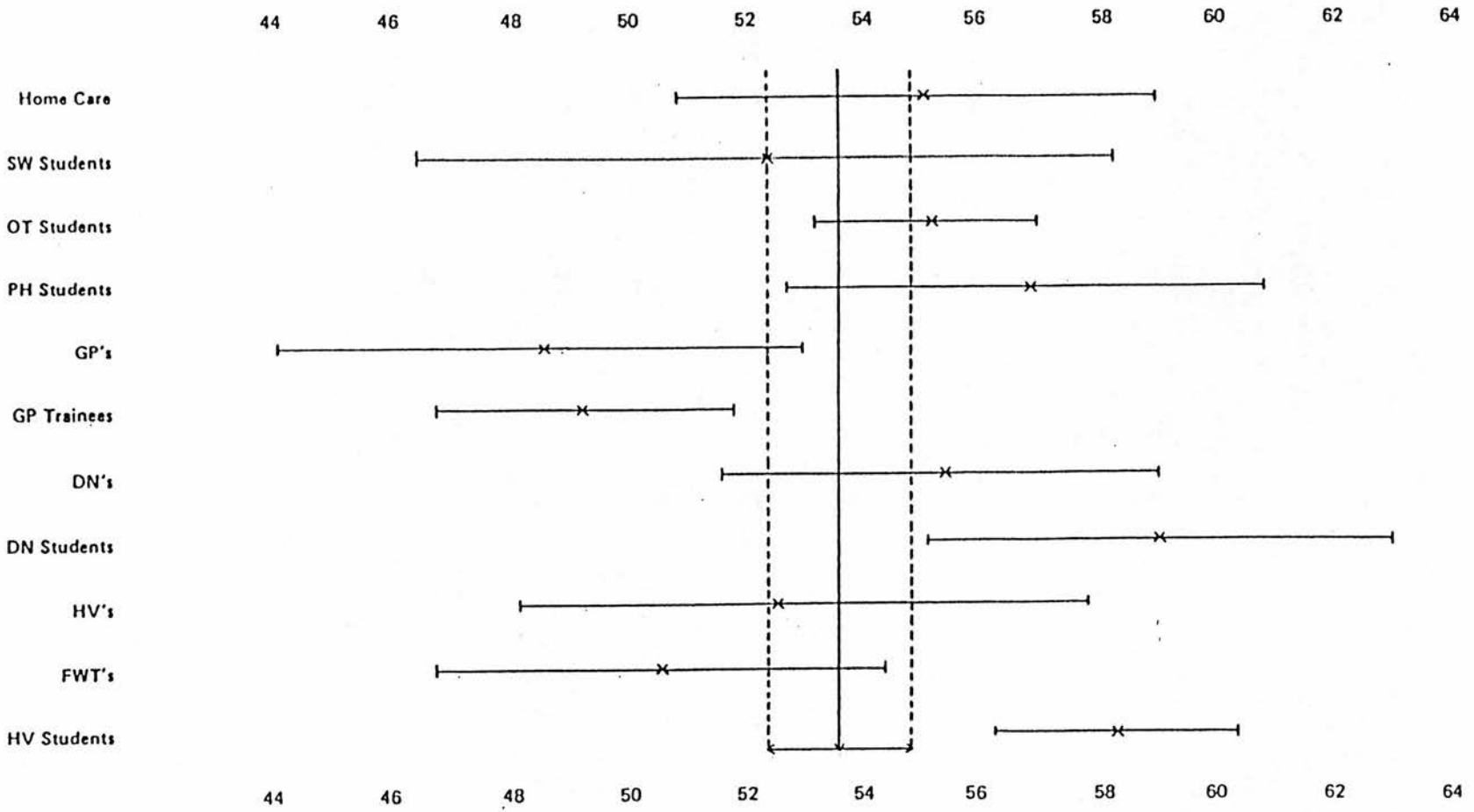

Figure 6. Semantic differential. Mean score of each group related to overall mean showing 95° confidence limits.

PATTERN OF RESPONSES

The three adjective pairs selected to investigate 'evaluative' feelings (bored/interested, cold/warm, reluctant/eager) were scored more positively than the rest. The other pairs were selected to reveal feelings about 'activity' and 'potency'. These three factors have been defined and described in the previous studies by Osgood using factor analyses. In the present study such analyses were not helpful, possibly because all the adjective pairs related mainly to one prime factor, and consequently plotting other factors against each other and against the prime factor did not demonstrate any clustering or separation of the adjective pairs. Again it would seem wise to interpret the results of this test with caution and to make comments on the basis of accepted usage of the meaning of words rather than on interpretations based on statistical analyses.

DIFFERENCES BETWEEN GROUPS

Figure 6 (opposite) shows the mean scores of the different groups in relation to the total mean score (showing 95% confidence limits). It can be seen that the experienced groups of district nurses and health visitors score lower than their student groups. District nurse students have the highest mean score which may be due to them being a group which has selected to work predominantly with older people. The two groups of general practitioners scored lower than the other groups. In considering the small difference between the scores of the trainees and the experienced general practitioners, it should be remembered that the experienced general practitioners were a self-selected group and presumably more interested than other general practitioners in the care of the elderly.

Similarly, the group of experienced health visitors was self-selected and it is therefore not surprising that they scored higher than the group of fieldwork teachers.

It is tempting to try to interpret and explain the small differences in rank order of adjective pairs between the groups but the difference may be due simply to chance. Tables VII-IX identifies by * or ° the adjective pairs and groups where scores were plus or minus two standard errors for the overall mean for the adjective pairs in question. For HV students, their overall high scores reflected the number of individual adjective pairs scoring which were consistently high. The overall low score of GP trainees was made up of consistently low scores on each adjective pair. In contrast, the small group of social work students appear to have a different pattern of responses from other groups, with organised/disorganised, relaxed/tense and precise/vague having low scores and quick/slow and warm/cold having high scores.

These differences are demonstrated in Figure 7 which shows the pattern of scores of the three groups.

SUMMARY

For all the tested groups, the general pattern of response in the semantic differential technique seems to be a consistent expression of interest and warmth towards visiting the elderly woman depicted on the video, with less positive scores on adjective pairs concerned with the likely effectiveness of the envisaged visit.

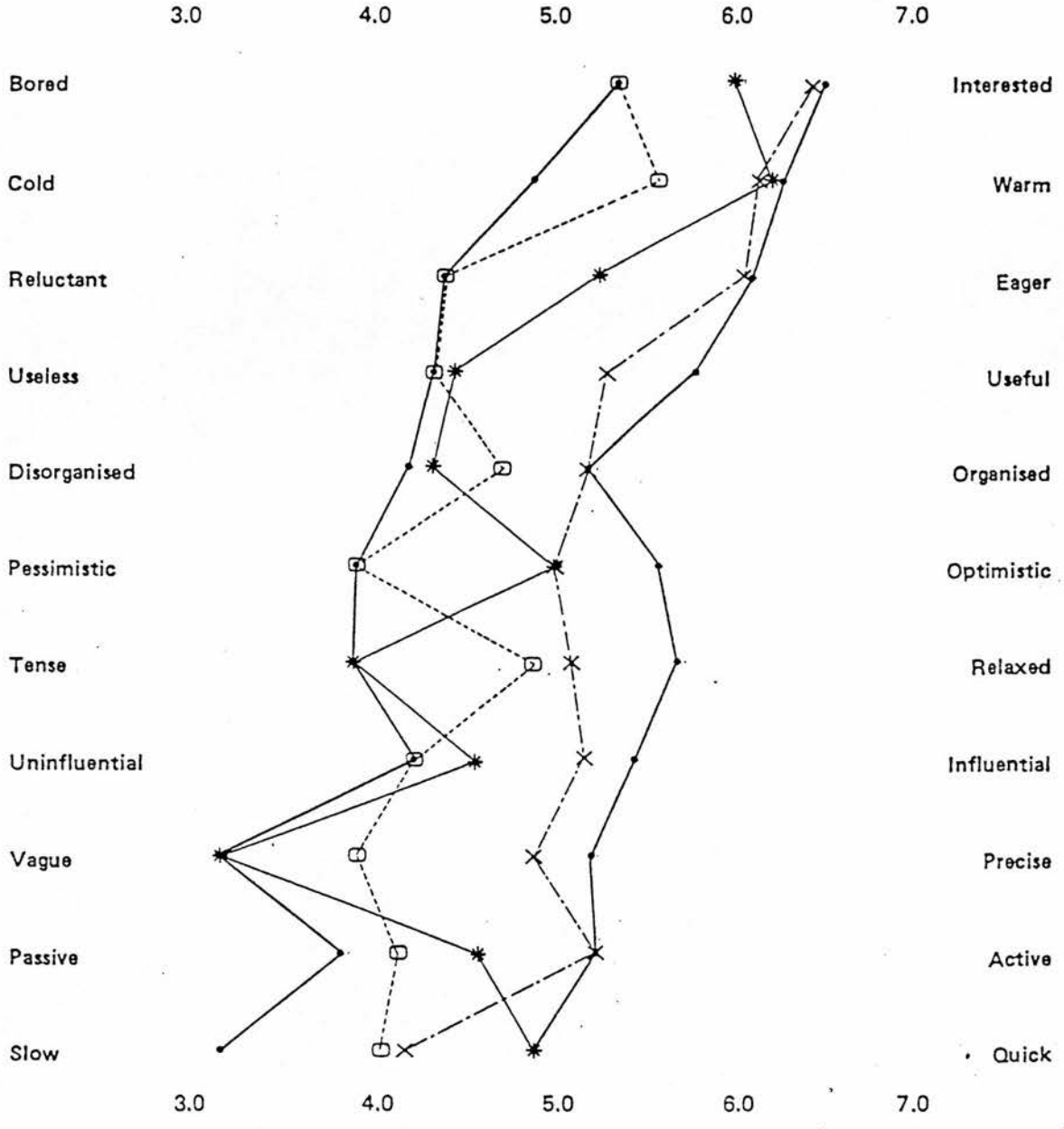

Figure 7 Semantic differential. Pattern of responses of GP Trainees ⊙——⊙ HV Students ×——× and Social Work Students ✳——✳ compared to range of means of all groups.

RESPONSES TO QUESTIONNAIRE

VIEWS AND FEELINGS ABOUT VISITING OLDER PEOPLE

Feelings ranging from enjoyment to anger were expressed in response to the questions about visiting older people at home.

> Health professionals have different views and feelings about visiting older people. How do you feel about visiting the elderly at home?
>
> Are there any particular experiences which have influenced your views about visiting the elderly - experiences during training, at work, with relatives or friends, etc. Please describe briefly.

The work of visiting elderly people was often described as worthwhile, rewarding, useful and satisfying. But it was also felt to be distressing, frustrating and depressing and it seemed that many of the study participants found assessment of older people at home difficult to carry out.

The majority in each professional group were positive about this part of their work, but many qualified their initial favourable comments with reservations. The health visitor groups showed the widest range of response, from the enthusiastically positive to the frankly hostile.

The general practitioner group were less inclinced than other groups to declare their actual feelings. They commented mainly about the organisation of their work rather than their feelings towards it. The physiotherapy and occupational therapy students also gave few expressions of feeling. They were the youngest groups and made fewer responses of any kind to these particular questions.

The amount and content of comment and the depth of feelings expressed varied considerably within and between groups, from brief comments such as 'I like visiting old people' and 'it is the most fruitful area of general practice' to tightly packed pages of detailed remarks including such words as 'horrendous' and 'disillusioned'.

SOURCES OF AMBIVALENCE

Health Visitors

The number of health visitors in each group expressing positive, negative and ambivalent views about visiting elderly people at home is shown in Table XII.

Table XII Health visitor groups: number expressing positive, ambivalent or negative views about visiting the elderly

Group	Positive views	Ambivalence	Negative views
Health Visitor Students			
Early in training (31 comments)	24	7	-
Late in training (37 comments)	20	16	1
Fieldwork Teachers (33 comments)	15	18	-
Other experienced Health Visitors (20 comments)	9	10	1

Negative views were given by only one health visitor student late in training and by one experienced health visitor. Positive views predominated in the student groups and ambivalent views in the experienced groups. Feelings of ambivalence were most frequently voiced by the fieldwork teachers. More student health visitors expressed feelings of ambivalence about visiting the elderly at the end of their training than at the beginning. When comparisons were made for the 26 students who answered the questionnaire both early and late in the year, it was found that eight students had changed their views, one in a positive direction and seven in a negative direction (Table XIII).

Table XIII Sources of ambivalence of HV students early and late in training about visiting older people

Category of comment	Early in training	No. of comments	Late in training	No. of comments
Focus of health visiting	Should start pre-retiral	1	Elderly visiting	1
Priority and Preference	For work with children	1	Other priorities	1
	Elderly are low priority	1	Competing priorities	1
Caseload	Too big	2		
	Couldn't cope if most of caseload were elderly	1		
Interviewing/ talking to older people	Time-consuming	2	Time-consuming	2
	These visits take longer	1		
Outcome	Unable to initiate change	1	Frustrated if nothing to show for visit except tick on KALAMAZOO	1
			Doubt value of follow-ups	1
Resources and services			Not available	4
			Long wait for sheltered housing	2
Work Organisation and team relationships			Poor organisation and sharing of work in team	2
			Not necessary for HV to do all the follow-ups	2
			Poor HV-GP communication	2
			Research inadequate	1
HV's perception of elderly people	Some likeable, some complain	1	Don't understand HV role	1
	Set in their ways	1	Too late to change habits	1
	TOTAL	12	TOTAL	22

Table XIV Sources of ambivalence of FWTs and other HVs about visiting older people

Category of comment	Fieldwork teachers	No. of comments	Other Health visitors	No. of comments
Focus of health visiting	Primary prevention and young elderly should be the priority	2	Should be preventive not crisis	3
Priority and preference	Competing priorities	1		
	Prefers mothers and children	2		
Caseload			Too big a caseload of under 5's	2
			Not enough time	1
Interviewing/ talking to older people	Visits time-consuming and longer than to other age groups	6	Time-consuming	1
Preparation/ training	Inadequate for work with old people	1		
Outcome	Doubt about value	2	Little I can offer	1
	Unable to change life style	1		
	Unable to meet needs	1		
Resources and services	Inadequate	2	Inadequate	2
	Lack of control over them	1		
	Unethical to raise expectations when services are poor	1		
Carers/families	Hostility of relatives	1		
Work organisation and team relationships	Poor HV/GP communication	1	Poor HV/GP communication	2
	HV should make her own referrals	1	Inappropriate responses from GPs	1
HVs perception of elderly	Set in their ways	1		
	Make their own choices	1		
	Conceal their problems	1		
	Unsure of HV role	1	Would like more visits than HV can offer	1
	Would like more visits than HV can offer	1		
	TOTAL	28	TOTAL	14

The students at the end of training tended to have reservations about the outcome of their work with older people, its organisation within the health care team and questioned whether appropriate resources and services were available. By the end of training, their views had become similar to those expressed by the experienced health visitors and field work teachers (Table XIV).

District Nurses

Table XV shows the number of district nurses in each group who expressed positive and ambivalent views about visiting older people. There were no negative views. The district nurse students, like the health visitor students, were mainly positive but, unlike health visitor students, the proportions of those expressing positive and ambivalent views did not change during the six months of district nurse training.

Table XV District Nurse groups: number in each group expressing ambivalent or positive views about visiting the elderly at home

Group	Positive views	Ambivalence	Negative views
District Nurse Students			
Early in training (24 comments)	19	5	-
Late in training (15 comments)	12	3	-
Experienced District Nurses	10	9	-

The views of 15 student district nurses were compared at the beginning and end of training. Four changed their views, two becoming positive and two becoming ambivalent.

The district nurse groups seemed to experience far less ambivalence than the health visitors and made comments in fewer areas than the health visitors (Tables XVI & XVII).

Table XVI Sources of ambivalence of DN students early and late in training about visiting older people

Category of comment	Early in training	No. of comments	Late in training	No. of comments
Focus of district nursing			Lack of primary preventive work	1
Preference	For more work with young people	1	For more work with a wider variation of age groups	1
Resources and services	Inadequate	3		
Team relationships			Poor back up from primary health care team	1
DNs perception of elderly people	Apathetic attitudes	1		
	Frustrating to work with	1		
	TOTAL	6	TOTAL	3

Table XVII Sources of ambivalence of experienced DNs about visiting older people

Category of comment		No. of comments
Focus of district nursing	Lack of time for preventive care of the well-elderly	1
Priorities	Competing demands on time (doing double duties as district nurse/midwife)	1
Resources and services	Getting aids	1
	Not enough sheltered housing	1
	Poor back up from hospitals	1
Carers and relatives	Relatives 'could do more'	4
	TOTAL	9

It was interesting to find remarks by some district nurses about their lack of involvement in primary prevention and about their preference for undertaking more work with younger rather than older age groups

General Practitioners

There were no negative comments from the general practitioner groups but considerable ambivalence was expressed about their work with the elderly. Nineteen out of 39 trainees and 17 out of 27 experienced general practitioners had reservations about their work with older people.

The general practitioners were more concerned than other groups about the outcome and effectiveness of home visiting and they held widely differing, and sometimes opposing, views about its organisation: for example 'crisis intervention better than routine visiting' and 'visiting should be pre-emptive and not crisis'.

General practitioner trainees (Table XIX) made detailed remarks about the difficulties of interviewing and assessing old people and about the inadequacy of training for this part of their work.

Table XVIII Sources of ambivalence of experienced GP's about visiting older people

Category of comment		No. of comments
Outcome/ effectiveness	Doubt value of 'routine' 'regular' 'social' or repeat prescription visiting	7
	Doubt value of 'systematic' visiting	1
Work organisation	Visiting should be 'pre-emptive' not 'crisis'	1
	'Crisis intervention' better than 'regular visiting'	1
	Visiting patterns should be flexible	1
	Visiting better done by paramedicals	2
Resources and services	Poor back-up from social, nursing and psychogeriatric services	3
Perception of elderly people	They become too dependent on GP	1
	Dislike intrusion	1
	Many don't want regular visits	1
	TOTAL	19

Table XIX Sources of ambivalence of GP trainees about visiting older people

Category of comment		No. of comments
Outcome/ effectiveness	Social/routine/regular visiting is inefficient use of time	5
	Visiting does not prevent problems	1
	Visiting does not cut down emergency calls	1
	Medically it is of little benefit	1
Work organisation and team relationships	Work needs to be organised and defined with other team members	1
	Assessment could be done by HV	1
	Selective visiting preferable	1
Priorities	Urgent/crisis calls take precedence	2
Interviewing/ talking to old people	Obtaining information is difficult	2
	Time-consuming	2
Preparation and training	Inadequate	1
Perceptions of elderly people	Some are likeable, some are not	1
	They resent intrusion	2
	They don't want to be a bother	1
	TOTAL	22

Occupational Therapy, Physiotherapy, Social Work students and Home Care Organisers

The physiotherapy students and home care organisers were mainly positive in their comments; the occupational therapy students and social work students expressed more ambivalence (Table XVIII).

Table XX Occupational therapy, physiotherapy and social work students and home care organisers: number expressing positive, ambivalent or negative views about visiting the elderly

Group	Positive views	Ambivalence	Negative views
OT students (9)	4	5	-
Physiotherapy students (20)	15	5	-
Social Work students (9)	4	5	-
Home Care Organisers (34)	29	5	-

The focus of ambivalence differed slightly for these groups and new areas of comment appear. For example, there was concern about whether the rights of elderly people were being recognised, and about areas of work which were difficult to handle (Tables XIX, XX).

Table XXI Sources of ambivalence of occupational therapy and physiotherapy students about visiting older people

Category of comment	Occupational Therapy students	No. of comments	Physiotherapy students	No. of comments
Interviewing/ talking to old people	More time-consuming than other work	4		
Difficult areas	Visiting demented and incontinent elderly	2	Visiting when the home is dirty	2
			Getting involved in social areas and problems	1
Perception of elderly people	Proud - they conceal facts	1	Dislike people intruding	1
	Don't welcome interference	1	Don't admit they can't cope	1
	Don't co-operate sometimes	1	Some make no attempt to help	1
	Set in their ways	1		
	Difficult to treat	1		
	TOTAL	11	TOTAL	6

Table XXII Sources of ambivalence of social work students and home care organisers about visiting older people

Category of comment	Social Work students	No. of comments	Home Care Organisers	No. of comments
Interviewing/ talking to old people	Time-consuming	1		
Resources and services	Inadequate	3	Sometimes need can't be met	1
Team roles	Confusing and difficult to sort out	1		
Rights of the elderly	Concerned about them	1		
Priorities	Work with elderly has low status	1		
Difficult areas	Confused old people	1	Financial and family problems	1
	Manipulative and selfish old people	1		
	Psychogeriatric work frightening	1		
Relatives and carers			Can be difficult	2
			Expect more than we can give	1
Perceptions of elderly people			Exasperating	1
			Don't want to be a bother	1
			They get confused when many professionals visit	1
	TOTAL	10	TOTAL	8

VIEWS AND FEELINGS ABOUT VISITING OLDER PEOPLE -THE MAJOR THEMES

From the wide variety of responses from the groups, it was possible to identify a number of themes common to all groups:

Purpose and value of visits
priorities and preference
skills and training
work organisation
team relationships
resources and services
feelings and rights of the elderly

PURPOSE AND VALUE OF VISITS

Uncertainty about the purpose of visits to older people and about the value of health assessments were the central themes to emerge from the replies to the questionnaire. For example, one general practitioner commented that visiting was carried out 'mainly because one feels that one ought to do it ... in the majority of cases the value of it is very doubtful'. Student health visitors experienced similar doubts about the purpose of visits to older people. One student remarked that her experienced fieldwork teacher had looked upon visits to old people as 'mostly social'. A general practitioner trainee commented 'I do not mind visiting the elderly, but find it difficult sometimes to know what to do, if it is not an acute problem'.

The other themes which were apparent in the responses largely stemmed from this central uncertainty about the purpose and value of home visits to older people. Until this uncertainty is removed it is difficult to see how primary health care teams can collaborate effectively in providing anticipatory care to the elderly or learn the appropriate skills to carry out the task.

PRIORITIES AND PREFERENCES

As anticipated, it was the groups of health visitors who made most comment about the problems of setting priorities in their work. This was expressed in terms of the relative importance of working with younger or

older sections of the community.

Although the health visitor groups felt that assessment of the elderly was an increasingly important part of their work, they felt that it received a low priority. Old people were described as 'last in the queue of priorities'. The low priority given to the elderly was contrasted with the high priority given to the pre-school child. Some health visitors felt the elderly were 'as important as young mothers and children' and deserving 'equal status with other groups'. In contrast, other health visitors still gave highest priority to the care of pre-school children. One experienced health visitor remarked 'the size of my present caseload of children under five, many with problems in the family, precludes assessment visiting of the elderly other than in response to a general practitioner or hospital referral'.

Doubts about the effectiveness of health visiting work with the elderly seem to contribute to a preference by health visitors for work with younger age groups. Many health visitors seemed to regard primary prevention as their most important contribution. One fieldwork teacher commented 'I believe totally in prevention but this necessitates visits early, ideally prior to retirement, rather than crisis intervention when problems become unbearable'.

However, by the end of their course some student health visitors had realised that preventive work with the elderly was feasible. One remarked 'I found it difficult initially to see working with the elderly as preventive, therefore it is not as simple as it is working with babies and children. I now realise that secondary or tertiary prevention can be just as important'.

Individuals in other groups also made comments indicating dilemmas in establishing priorities of work. A general practitioner trainee remarked that 'visiting and assessing elderly people can be of low priority and temporarily put off'. Another said 'too much home visiting chokes the visit book and leaves less time for the people who are ill and those who need support on a short term basis'.

The views of district nurses were rather different from other groups in that they already spend the majority of their time with older people. Some district nurse students wished to have more involvement with younger age groups. Both student and experienced district nurses wished to expand their role 'to visit the well elderly with the emphasis on prevention rather than curative nursing'.

SKILLS AND TRAINING

'I personally feel a bit inadequate at present in assessing the needs of the elderly in view of my lack of formal training in this discipline. This tends to make me less keen to visit the elderly at present'. This comment by a trainee general practitioner was echoed by other participants in all the professional groups. Assessment was seen as a vague and difficult activity. A health visitor said, 'I feel in general that the health visitor and the students are not given sufficient guidance; it is a specialised area'. In contrast, the assessment of pre-school children was not perceived as a specialised area by the health visitors. It was accepted as a priority aspect of work for which special preparation was available.

Differences were perceived between rhetoric and reality in training. A social work student remarked that in her training the elderly were considered 'worthy of equal respect' but in reality there was 'a feeling in social work that work with the elderly has low status; that the elderly do not warrant the same intervention and attention as other groups, for example, children'.

Two difficulties in assessing older people at home were voiced by all groups. First, the assessment of older people was seen as a time-consuming activity and, second, it was felt that there are sensitive areas about which it is difficult to enquire and which old people are reluctant to discuss. These issues relate to interview techniques, the nature of the relationship the professional worker has with an older person and the reactions of the health workers to some of the situations they encounter in dealing with older people.

(a) Interview technique

Interviewing older people was regarded by many of the participants as time-consuming and one reason for this seemed to be that health professionals felt the need to listen to old people who appeared 'lonely and isolated'. An occupational therapy student said 'a lot of them seem to be very lonely and talk for hours, which I find too difficult to cope with'. Ability to cope with this problem was acknowledged by an experienced health visitor to be a matter of interviewing skills; when she was successful in 'controlling the interview sensitively' then visiting older people gave great job satisfaction.

(b) Nature of relationship with older person

Connected with the concept of control described above was a recognition that professional people are guests in an older person's home. Some of the students recognised that the home setting altered the 'balance of power' in an interview. In addition to the uncertainties in the minds of professionals about the purpose and scope of their visits to older people, health visitors felt that clients did not have a clear perception of their role. In the midst of uncertainty about the purpose of visits and feeling a lack of control in interviews, it is not surprising that some of the respondants felt that they were swept along on a conversational tide. Consequently for some, the social context of the interaction with the elderly person made enquiry difficult into intimate aspects of health such as bladder and bowel function.

Some health visitors saw the need for several visits before seeking sensitive information and made comments such as 'relationship-making was an investment for the future' and 'you only get a tru picture after several visits'. This may be true but it may also indicate a lack of confidence and skill in their interview technique.

(c) Personal Reactions

Visiting some older people at home had been a difficult and sometimes disturbing experience for some of the study participants. One social work student said 'I find it difficult to confront elderly frail people

who are manipulative and selfish'. A physiotherapy student felt 'sad to see that they are letting their homes run down'. An occupational therapy student commented 'I have mixed feelings, some visits to elderly people are interesting and enjoyable and others are horrendous, e.g. when the person has been very incontinent'. Elderly people suffering from dementia and incontinence and living in poor and sometimes dirty home conditions disturbed a number of the students. General practitioners and health visitors experienced in working with older people in the community are likely to have seen demented and incontinent patients on many occasions and their own first reactions may have been forgotten. The remarks from students above are a reminder to older and more experienced professionals to consider the reactions of their younger and less experienced colleagues to whom they may be making referrals.

WORK ORGANISATION

Uncertainties about the purpose of health assessments were reflected in comments about the ways in which visiting older people was organised. The purpose of a visit will influence and be influenced by the timing of it. The group of experienced general practitioners were particularly concerned about how they could best organise visits to older people. Several doctors questioned the value of 'routine', and 'pastoral' visiting. These doctors felt that a more systematic approach to visiting was required with improved selection of those people who were particularly vulnerable to deterioration in their health.

A number of the younger general practitioners had inherited from older doctors large numbers of elderly patients who were accustomed to being visited each month.

'I inherited regular chronic visits, all done once a month. I am slowly changing to a more flexible pattern. A small proportion of the population considered to be at risk are visited by me. It should be done by all members of the primary care team ... we should be flexible, increase (contact) in a crisis, decrease quickly when the crisis is over and should divorce the association between regular visits

and repeat prescriptions'.

The selective visiting of elderly people most at risk of deterioration in their health was the preferred approach of most of the experienced general practitioners. However, some doubted the feasibility of providing anticipatory care in this way. One doctor remarked 'my visits are not pre-emptive but usually crisis intervention. Ideally they should not be'.

The general practitioner trainees were specifically asked to describe the way in which home visiting of the elderly was organised in their training practice. Several trainees questioned the policies adopted and had reservations about the effectiveness of visits to older people other than for acute problems. Some training practices did not have any agreed policy. Each partner was seen to have a different way of working. Visiting older people at home ranged in the training practices from 'by request only' to 'systematic surveillance'.

A 'routine' visiting system was frequently mentioned by the trainees and often questioned. The usual 'routine' pattern described by the trainees was: 4 to 6 weekly visiting of; the housebound, the disabled, those living alone or socially isolated, those with special health problems or social difficulties and those on regular medications. One trainee found that 'routine' visiting was actively discouraged by his practice because 'it was inefficient'. Other trainees after some experience of routine visiting had started to question its value. 'My trainer believes very strongly in regular visiting. Initially, I was also enthusiastic but have become less convinced about its effectiveness'. Opinions and experiences within the group of general practitioner trainees differed widely.

The student health visitors expressed similar doubts about the organisation of visits to older people. Experienced health visitors did not describe in detail their methods of organising their contact with elderly people. Instead they concentrated on what they felt they could offer and gave examples illustrating what could be achieved. 'Health improvement for a poorly nourished old man following the introduction of home help and meals on wheels'. 'Introducing an isolated old person to other elderly people living in the same area'.

Recurring themes for all the professional groups relating to the organisation of their work were:

the very wide scope for work with older people which it is possible for a health professional to tackle.

the considerable overlap in function between different professional groups

the problem of determining the work with the elderly which is appropriate for the different professional groups.

This final theme links to the question of team relationships and is considered next.

TEAM RELATIONSHIPS

The tone of many of the comments suggested that good relationships and good communication existed between professional groups but clearly this was not always the case. Two general practitioners remarked:

> 'I would have liked the health visitor to work with the elderly but our relationship and communication are far from ideal'.

> 'The health visitor is not attached to the practice; although the relationship is good it does not extend to discussing each other's workload'.

Two health visitors made similar comments about the attitudes of general practitioners:

> 'I feel helpless because of the general practitioner's attitude. I would find it more rewarding if the general practitioner participated in discussion and assessment of the elderly'.

> 'Since I have little contact with the general practitioners, visiting is not as valuable or as structured as it should be'.

Inappropriate referral was a recurring problem. For referrals from general practitioners to health visitors, there sometimes appeared to be tension between the general practitioner's concern to find help for a difficult problem and a health visitor's preference for making contact 'early rather than late'. It was difficult to reconcile the need to cope with crises with the wish to concentrate on prevention. A health visitor commented:

> 'The general practitioners are continually complaining about their large elderly case load and that they only seem to have time to visit them at a time of crisis. When they feel particularly hard pressed they make referrals to health visitors, which are sometimes most inappropriate (when there is little to be done because the situation has got out of hand). I think health visitors could be of more use if they received general practitioner referrals earlier'.

Referrals from health visitors to general practitioners were also problematic.

Responsibility, accountability and professional competence were major issues for some of the participants. A fieldwork teacher who had many years experience remarked:

> 'I feel resentful that after making my assessment many referrals in my area have to be made by the general practitioner for wheelchairs, chiropody, speech therapy etc. I can write my own letters after doing the assessment'.

There was also anxiety about 'duplication of visiting'. Several professionals could be knocking on the same door, each one failing to get in touch with the others involved. Lack of knowledge of respective roles was thought to be one cause of the problem, but lack of though, discussion and co-ordination were also important. A home care organiser succinctly described the problem and raised the important question, 'how does the old person feel about it all?'

> 'I am worried about the number of disciplines that visit an elderly person during a crisis period. For example, when discharged from hospital, the doctor, district nurse, health visitor, occupational therapist, social worker, minister and home care organiser may all visit. Very often this causes distress, confusion and a reluctance to accept services. Perhaps an integrated, co-ordinated approach would be more acceptable'.

RESOURCES AND SERVICES

Every group, except the general practitioner trainees, made some comments about 'frustration' with 'lack of back-up from health and social services'. The main concerns were in the areas of finance,

housing, loneliness, equipment, help for confused elderly at home, lack of places in day centres, lack of transport and lack of chiropody.

It may be that the general practitioner trainees did not voice these frustrations because most of their experience had been in the episodic management of illness rather than in continuing contact with older people with chronic problems.

In contrast, assessment of chronic disabilities, obtaining the services of other health professionals and referral to a wide range of agencies were key parts of health visiting work. Both student and experienced health visitor groups commented frequently about their difficulties in these areas. The remarks of the student health visitors displayed considerable depth of feeling:

> 'I feel useless if the services required are not available. Identifying need without resources is disheartening'.
>
> 'It takes such a long time to implement changes for them, especially regarding sheltered housing'.
>
> 'I have become disillusioned and discouraged. I think the elderly are neglected beyond belief. Services are virtually unobtainable and sheltered housing is bordering on a myth - for at least five years - in many cases the life span of the people requiring it'.

With the student groups in particular there was a feeling that they needed 'to do something'. They wanted to offer 'practical help' usually in the form of the services of other agencies and often this was not possible. There were feelings of frustration, guilt and even 'bitterness'. Understanding the nature of practical action within health visiting and teasing out the contribution that might be made directly by the health visitor herself, and indirectly by others through her, seemed to be areas of uncertainty. One student remarked that she felt guilty if she spent time visiting and then had 'nothing to show for it other than a tick on the visiting schedule'.

One of the district nurse students had been working for two years as a health visitor before starting her training. At the beginning of her course she said:

> 'I feel that as a district nurse I will find more fulfilment in caring for the elderly than I did as a health visitor, where lack of resources restricted in many instances the service I was able to offer'.

By the end of the course six months later it seemed that the frustration persisted:

> 'It is a challenging aspect of work despite the fact that there are many frustrations to contend with, particularly when trying to obtain support and back-up facilities from other members of the primary health care team, or other agencies'.

The students were not alone in their rather negative feeling about resources. An experienced general practitioner echoed their concerns and also raised the issue of different contractual relationships between general practitioners, health visitors and district nurses as a further source of tension:

> 'With little or no support from geriatricians, nursing organisation and chiropody services, it is very frustrating. The levels of care aspired to are impossible to implement because of the failure to provide services. Inadequate staffing and management of district nursing and health visitor services make any rational anticipatory care from other agencies impossible'.

Despite the frustrations about team relationships, the organisation of care and the lack of resources, there were many positive remarks, which showed that the professional groups felt they had a great deal to offer at a personal level and collectively in assessing and helping old people at home.

FEELINGS AND RIGHTS OF THE ELDERLY

Within all groups there was evidence of sensitivity to the feelings and the rights of old people. For example, old people were regarded as

welcoming and appreciative of visits and it was felt that they enjoyed the company and contact with health professionals. However, some distrusted 'interference' and resented 'prying'. Many had considerable pride in themselves and their circumstances, were fiercely independent and reluctant to 'accept charity'. Others felt that it was their right to 'have the general practitioner keep an eye on them'. It was thought that those who expected regular visits might perhaps become unnecessarily dependent upon the professional.

It was acknowledged that whereas some old people 'didn't like to be a bother', others welcomed 'being of interest'. Some actively sought help for their difficulties and disabilities while others felt 'it's just old age', 'nothing can be done' and 'ther's always somebody worse off than me'.

Professionals had experienced both 'co-operation' and 'resistance to change'. It was recognised that an old person and a health professional might not share priorities and points of view and this could be 'exasperating', but it was noted that old people should have 'every right to refuse help' and 'could choose to live with risks'.

Whatever the balance of success or failure experienced by individuals in their work with the elderly, it was striking that all groups commented about the rewards of working with old people. Many of the younger participants remarked about how much they had learned. Hearing about 'memories and experiences' was a great pleasure.

> 'I gain something from each visit; it does give me a different outlook on life'.
>
> Home care organiser

'You get splendid feedback ... a historical record. This is more than just a personal indulgence'.

General practitioner trainee

'I enjoy visiting the elderly as they have a whole lifetime of memories and experiences and love to tell young people about their lives'.

Health visitor student

PROMPT LIST - SCOPE AND CONTENT OF ASSESSMENT

In Part I surveys of the health needs of older people have been described. These surveys have used different methods and there have been few attempts to validate particular approaches.

Detailed protocols of assessment are of value if attempting to define the health needs of large populations in simple terms using unskilled interviewers. They have not been generally adopted by health professionals in their continuing assessment of the health needs of the elderly.

The health visitors, district nurses and doctors who were interviewed at the outset of the study were opposed to the introduction of detailed protocols in their assessment of older people. They did express a wish to have guidelines about the overall scope and content of assessment, but wished to remain flexible about the way in which the health needs of individual older people were assessed. The video-recorded interviews demonstrated the idiosyncratic routes taken in interviews, even when attempts were made to follow a set schedule.

There are several possible reasons for the resistance by health professionals to the use of protocols in their work. Protocols in this context can serve two distinct functions. First they can set out a schedule for an assessment interview by specifying the exact questions which should be asked by the interviewer in an attempt to gather responses which are not influenced by a particular interviewer and so produce reliable information. Second they can be used to record information about an elderly person in a standard format. Neither of these functions is of prime interest to the health professional who is involved in the care of an elderly person. The first function serves the needs of investigators who are interested in the health status and needs of populations. The second function serves the needs of health managers who are interested in the allocation of resources for the health care of older people and in assessing the performance of individual nursing or medical practitioners.

Practitioners are likely to be frustrated by the imposition of standard

formats for their record keeping unless they save time and can be used flexibly. Ante-natal record cards are found to be helpful because they focus attention on the few important clinical features in pregnancy and provide a mechanism for detecting abnormal changes in features such as blood pressure and weight at a stage when intervention is beneficial. The record cards also provide a method of communication between community and hospital staff. In contrast, for older people there is no predictable clinical feature which requires attention and for an individual elderly person a fixed protocol of assessment is likely to be over-elaborate in some areas and provide insufficient scope for detailed enquiry in other areas.

The responses of participants in the video studies showed that individuals had important gaps in their approach to assessing the health needs of an older person. In order to try to help health professionals in a practical way, guidelines for the scope and content of assessment were created in the form of a prompt list. The format of a list was adopted because it is simple and can be presented on one sheet of paper. A list can be used as an aide memoire to ensure that all potentially important areas of function are assessed but does not force assessment interviews to proceed in a set way.

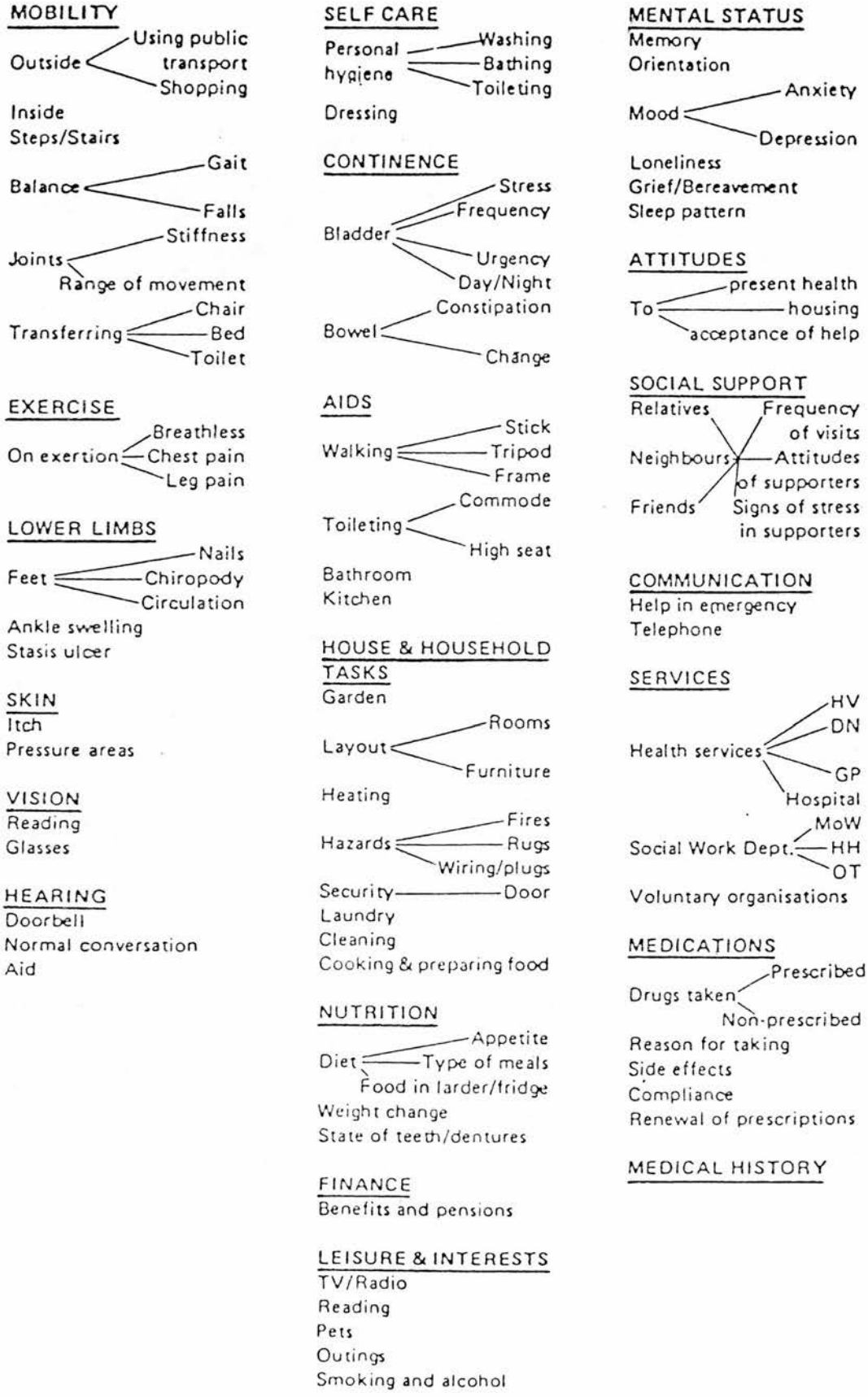

Figure 8.1 Prompt list for health assessment of the elderly.

DERIVATION OF PROMPT LIST

In the first part of the video study the responses of the health visitor students were categorised under 46 different headings. It was possible to use these categories to analyse the responses from all the other study groups.

Appendix III shows the different categories together with the range of responses within each category. The asterisks identify the responses selected for inclusion in the Prompt List. It can be seen that with the exception of a medical examination, items from all 46 categories are included. Thus, whilst the list is a personal selection, it does also reflect the responses of all the participants in the different professional groups (Figure 8.1).

The grouping of some sections is straightforward, for example mobility. Other items such as 'toileting' refer to abilities which can be impaired by different types of physical or mental deficits. Thus 'toileting' appears twice on the sheet, once under the heading 'Self-care' and again under 'Aids'.

Although this is the only duplication on the sheet, it is clear that the categories are not self-contained. Functional impairment in any one category has possible implications for function in other areas.

The order of headings on the sheet was designed to place similar categories close to each other and to emphasise the importance of attributes and abilities which are at the top of the sheet. If an older person does not have problems in the areas of mobility, mental status, attitudes, self-care and continence, then there may be no need to progress through a detailed assessment of the other functional categories. Conversely problems in these basic functions does mean that detailed knowledge of abilities in other areas is desirable.

FIELD STUDIES

Because the list had been created from the responses of students and practitioners to a video-recording showing just one elderly person, it was important to discover whether the list had relevance to the assessment of other elderly people and whether the responses given in a classroom setting were seen as appropriate by practitioners in the field. For these reasons the Prompt List was used as the basis for analysing the knowledge of a number of older patients held by members of the primary care team in two centres in Edinburgh.

Although geographically close to each other, the two centres are very different. One is a large health centre containing 5 different general practices and one of these practices co-operated in the study. The other centre is a converted doctor's house containing a single practice. The centres were selected because the active co-operation of general practitioners, health visitors and district nurses was assured.

In neither practice was a systematic system of anticipatory care for the elderly in operation, although in both there was interest in preventive care of older people and regular visiting of the housebound elderly was carried out by general practitioners and health visitors.

By examining the records of district nurses, health visitors and general practitioners in these two centres, patients were identified who were being visited by, or who had contact with, district nurses, health visitors and general practitioners.

In view of the emphasis in the literature on a team approach to assessment of older people in the community, it was of interest to discover that few patients were being visited concurrently by district nurses, health visitors and general practitioners. General practitioners were in contact with all the elderly patients seen by the health visitors and district nurses but the reverse did not apply and only very few patients were seen by both health visitors and district nurses.

MOBILITY

Outside — Using public transport; Shopping •o

Inside x•o

Steps/Stairs x

Balance — Gait; Falls •

Joints — Stiffness; Range of movement

Transferring — Chair; Bed; Toilet

EXERCISE

On exertion — Breathless x•; Chest pain •; Leg pain xo

LOWER LIMBS

Feet — Nails; Chiropody •; Circulation •

Ankle swelling •

Stasis ulcer

SKIN

Itch

Pressure areas o

VISION x•

Reading x

Glasses •

HEARING •

Doorbell

Normal conversation Aid

SELF CARE

Personal hygiene • — Washing; Bathing o; Toileting

Dressing

CONTINENCE

Bladder — Stress; Frequency •; Urgency; Day/Night •

Bowel — Constipation •; Change

AIDS

Walking — Stick; Tripod •; Frame

Toileting — Commode; High seat

Bathroom x

Kitchen

HOUSE & HOUSEHOLD TASKS •

Garden

Layout — Rooms x•o; Furniture •

Heating •o

Hazards — Fires; Rugs; Wiring/plugs

Security — Door

Laundry

Cleaning o

Cooking & preparing food •

NUTRITION

Diet — Appetite •; Type of meals •; • Food in larder/fridge

Weight change

State of teeth/dentures •

FINANCE •

Benefits and pensions

LEISURE & INTERESTS •

TV/Radio

Reading

Pets x

Outings

Smoking and alcohol •

MENTAL STATUS

Memory x•

Orientation x•

Mood — Anxiety x•; Depression

Loneliness

Grief/Bereavement

Sleep pattern •

ATTITUDES

To — present health x•; housing x; acceptance of help x•o

SOCIAL SUPPORT

Relatives x•o; Neighbours •; Friends •

Frequency of visits; Attitudes of supporters; Signs of stress in supporters

COMMUNICATION

Help in emergency

Telephone x•

SERVICES

Health services — HV x•; DN x•o; GP x; Hospital x•

Social Work Dept. — MoW o; HH x•o; OT

Voluntary organisations

MEDICATIONS

Drugs taken — Prescribed x•; Non-prescribed

Reason for taking x•

Side effects x•

Compliance x

Renewal of prescriptions

MEDICAL HISTORY

x•o

x = GP
o = DN
• = HV

Figure 8.2 Prompt list: areas of information offered by GP, HV and DN.

The district nurses had the smallest number of patients in their record system, and using these records as a starting point, the first patients who were also visited by a health visitor and also by one of the seven general practitioners were selected. This small sample of seven patients is thus a highly selected one. It was felt necessary to select patients on this basis so that the responses of each member of the primary care team could be directly compared.

Information about the patients was first extracted from the different sets of records. Each member of the team was then interviewed separately about their knowledge of the patient and finally the prompt list was issued to provide an aide-memoire to enable gaps in the assessment to be filled in. The interviews were recorded and the analysis of the responses carried out from the typed transcript. The detailed analysis was done in the same way as for the video study and subsequently summarised on to the prompt list itself.

For illustration, the responses for one patient are given on the series of prompt lists (Figures 8.2-4). The lady in question had multiple medical problems, lived in adequate housing with her sister and was reluctant to accept help. The pattern of responses given for this lady was similar to that given for the other cases studied.

INFORMATION OFFERED

The unprompted material (Figure 8.2) showed very clearly the focus of interest of the different team members. In the example given, the general practitioner started his description of the patient by describing previous illnesses and present medications. He then progressed to a detailed account of current problems with mobility and continence. His comments about the capability of the patient to carry out household tasks and self-care were vague. He knew that a home help was attending but his knowledge of contact was not as precise as that of the health visitor and district nurse. He gave a graphic account of the behaviour of the patient and then described the nursing care which had to be provided. The district nurse's knowledge of the previous illnesses suffered by the patient

MOBILITY

Outside — Using public transport; Shopping •

Inside •

Steps/Stairs

Balance — Gait x; Falls •

Joints — Stiffness; Range of movement

Transferring — Chair; Bed; Toilet

EXERCISE

On exertion — Breathless x•o; Chest pain x•o; Leg pain

LOWER LIMBS

Feet — Nails; Chiropody •o; Circulation •

Ankle swelling •

Stasis ulcer

SKIN

Itch

Pressure areas

VISION x•

Reading x

Glasses •

HEARING x•

Doorbell

Normal conversation •

Aid

SELF CARE

Personal hygiene • — Washing; Bathing; Toileting

Dressing

CONTINENCE

Bladder — Stress; Frequency •; Urgency; Day/Night •

Bowel x — Constipation •; Change

AIDS

Walking — Stick •; Tripod; Frame

Toileting — Commode; High seat

Bathroom

Kitchen

HOUSE & HOUSEHOLD TASKS •

Garden

Layout — Rooms •o; Furniture •

Heating •

Hazards — Fires; Rugs; Wiring/plugs

Security — Door

Laundry

Cleaning •

Cooking & preparing food •

NUTRITION

x•o

Diet — Appetite •; Type of meals •; Food in larder/fridge

Weight change x

State of teeth/dentures •

FINANCE

Benefits and pensions

LEISURE & INTERESTS •

TV/Radio

Reading

Pets

Outings

Smoking and alcohol x

MENTAL STATUS

Memory •

Orientation •

Mood — Anxiety •; Depression

Loneliness

Grief/Bereavement

Sleep pattern •

ATTITUDES

To — present health x; housing; acceptance of help •

SOCIAL SUPPORT

Relatives x•o — Frequency of visits

Neighbours • — Attitudes of supporters

Friends • — Signs of stress in supporters

COMMUNICATION

Help in emergency

Telephone x•o

SERVICES

Health services — HV •; DN xo; GP x•o; Hospital x•

Social Work Dept. — MoW; HH x•o; OT

Voluntary organisations

MEDICATIONS

Drugs taken — Prescribed x•; Non-prescribed

Reason for taking x•

Side effects x•o

Compliance

Renewal of prescriptions

MEDICAL HISTORY

x•o

x = GP
o = DN
• = HV

Figure 8.3 Prompt list: areas of information noted in GP, HV and DN records.

was scanty and sometimes wrong. The health visitor mentioned a much broader range of categories than either the district nurse or the general practitioner and was clear about the sources of support received by the elderly person.

RECORDED INFORMATION

The district nurse records (Figure 8.3) concentrated on the practical care given. The health visitor records provided a detailed picture of the functional ability of the patient and included information about the home environment, family contact and other supporting services. The general practitioner records concentrated largely on illnesses, investigations and medical treatment with little information about functional capabilities.

PROMPTED INFORMATION

Providing the prompt list (Figure 8.4) caused both the general practitioner and district nurse to add a considerable amount of information. It was clear that all three members of the team knew a great deal about the patients. The prompt list did demonstrate that there were still small gaps in the overall knowledge of the team about their elderly patients. For the individual documented in Figures 8.1 - 8.4 detailed knowledge was lacking about; some self-care abilities, nutrition and possible weight change, joint function and the ability to transfer, and there was no knowledge about the probable consumption of non-prescribed medications.

Good personal relationships between the different members in the two teams were evident. For the older woman described in Figures 6b,c,d, the district nurse saw herself as providing practical care. She visited twice a month to supervise bathing and was able to check pressure areas and check for other possible problems. She considered she was giving support and emphasised that the patient knew how to get in touch with her if necessary. Similarly, the general practitioner felt himself to be providing support by being available by telephone in addition to his regular visits once every two months. His view of the role of the district nurse fitted with her own perception of her role. However, he

MOBILITY

Outside — Using public transport xo; Shopping x

Inside

Steps/Stairs o

Balance — Gait xo; Falls x

Joints — Stiffness x; Range of movement

Transferring — Chair; Bed; Toilet o

EXERCISE

On exertion — Breathless o; Chest pain o; Leg pain xo

LOWER LIMBS

Feet — Nails; Chiropody xo; Circulation o

Ankle swelling xo

Stasis ulcer x

SKIN x

Itch

Pressure areas x

VISION

Reading o

Glasses o

HEARING

Doorbell x

Normal conversation xo

Aid x

SELF CARE

Personal hygiene x — Washing; Bathing; Toileting

Dressing x

CONTINENCE

Bladder xo — Stress; Frequency; Urgency; Day/Night

Bowel xo — Constipation; Change

AIDS

Walking — Stick xo; Tripod; Frame

Toileting — Commode x; High seat o

Bathroom

Kitchen x

HOUSE & HOUSEHOLD TASKS

Garden x

Layout — Rooms xo; Furniture

Heating x

Hazards — Fires; Rugs xo; Wiring/plugs

Security — Door x

Laundry o

Cleaning xo

Cooking & preparing food x

NUTRITION

Diet — Appetite o; Type of meals; Food in larder/fridge

Weight change x

State of teeth/dentures o

FINANCE o

Benefits and pensions

LEISURE & INTERESTS

TV/Radio o

Reading o

Pets

Outings x

Smoking and alcohol

MENTAL STATUS

Memory o

Orientation o

Mood — Anxiety o; Depression

Loneliness x

Grief/Bereavement x

Sleep pattern xo

ATTITUDES

To — present health o; housing; acceptance of help

SOCIAL SUPPORT

Relatives; Neighbours; Friends o — Frequency of visits; Attitudes of supporters; Signs of stress in supporters

COMMUNICATION

Help in emergency

Telephone o

SERVICES

Health services — HV; DN; GP; Hospital

Social Work Dept. — MoW; HH; OT

Voluntary organisations

MEDICATIONS

Drugs taken — Prescribed •; Non-prescribed

Reason for taking

Side effects

Compliance

Renewal of prescriptions x

MEDICAL HISTORY

x

x = GP

o = DN

• = HV

Figure 8.4 Prompt list: extra information from GP, HV and DN prompted by the list.

saw the health visitor as 'helping' by supporting the family relationship through talking to the patient's sister. On a practical level, he saw the health visitor as being able to assess the needs for mobility aids. The general practitioner's impression that the health visitor was providing continuing contact was not shared by the health visitor herself. Whilst she had carried out a detailed assessment, this had resulted in her being able to withdraw from frequent contact and she had left it up to the patient to make the next contact if required.

Each member of the team felt that the prompt list was helpful in avoiding gaps in the assessment and that having a common structure to assessment might enable teams to pool their knowledge more effectively.

The prompt list did seem to be of help to members of the primary care teams. It was seen as relevant and useful. By emphasising the common nature of health assessment, the list may enable members to communicate more effectively with each other about an individual's health needs.

The field studies were limited in their intentions. No attempt was made to test the reliability or reproducibility of the prompt list as a tool in assessment. This could be attempted but was not the focus of interest in this phase of the research. My intention was to learn more about the way in which professionals perceive the nature of health assessments and undertake this activity rather than to test specific methods of assessment.

PART III

PART III

INTRODUCTION

From the review of the literature and the exploratory studies described in Part I, I formulated three broad aims. I wished to:

1. Describe the scope and content of health assessments of older people at home as perceived by different professional groups and by older people themselves.
2. Provide information on the views and feelings of different professional groups towards visiting and assessing the health of older people at home.
3. Describe how different health professions perceive their own role and the role of others in assessing and responding to the health needs of older people at home.

I went on to list seven specific questions relating to these broad aims. In Part III, I shall discuss the results of the studies described in Part II in relation to these seven questions before considering the implications of the results for the future of health care for older people.

First I wish to discuss briefly the validity of the studies described in Part II. A more detailed defence is contained in Appendix V.
The video and questionnaire studies are qualitative rather than quantitative. I have not found it a comfortable area to work in. Although the collation, sifting and selection of important items of information is an activity which I carry out daily in my clinical work, this activity in a research setting caused me considerable feelings of uncertainty. I started out with hopes of creating and defining a concrete case finding package, the use of which would transform the health of older people at home. Instead my research has taken me backwards into questioning the assumption that a case finding package would be of benefit.

The methods and techniques I used are those of the behavioural sciences rather than physical sciences and the results require to be interpreted in that context.

I have examined a broad area of clinical practice for several different professions. Although efforts were made to standardise the context in which questions were posed to the participants, the studies were designed with the aim of understanding the complexities of a clinical activity. For example, the open ended questions resulted in responses which were difficult to analyse but perhaps throw more light on the issues involved in the assessment of older people than would emerge from a more structured questionnaire. It can be argued in the behavioural sciences that there is a fundamental dilemma between the validity and reliability of information.

Behaviour is influenced by a large number of factors which may be difficult to identify and quantify. Eliminating or controlling certain factors in an experiment may result in achieving reproducible observations but at the expense of being able to assume that the findings are generally applicable.

The video studies were an attempt to strike a balance between the real world portrayed in the recordings and a classroom setting in which it was possible to collect information from a large number of people in a standard manner.

Although some of the study groups were self-selected on the basis of their interest in the care of older people in the community, the total number of participants and the high level of agreement between the different groups supports the validity of the results. The observed differences between groups are of a lesser order of importance than the levels of overall agreement and have not been emphasised in the presentation of the results.

DISCUSSION OF RESEARCH QUESTIONS

1. DO HEALTH PROFESSIONALS PERCEIVE THE HEALTH NEEDS OF AN OLDER PERSON AT HOME IN THE SAME WAY?

Although there was agreement between groups about the major actual or potential health needs of the two older women portrayed on the video excerpts, there were important differences in the way in which the problems were perceived. These differences reflected different professional perspectives. For example, some general practitioners considered that the elderly woman portrayed in the first video excerpt required to have a hip operation. This contrasted with the views of health visitors and student physiotherapists. Some of the health visitors recommended that the woman be provided with a higher chair and the student physiotherapists suggested that advice and training should be provided in order to help the elderly woman learn how to transfer from a sitting to a standing position.

These differences in perspective are perhaps predictable but do indicate that a multi-disciplinary approach may lead to a wider range of therapeutic possibilities being available for consideration by a disabled elderly patient than would occur if only assessed by one profession.

Other differences in the perception of the older woman shown in the first video excerpt did not relate to different professional backgrounds. Individuals within the same group saw the older woman as cheerful whilst others saw her as sad. Although one would expect health and social services personnel to check out their first impressions, these remarks indicate that respondents may bring to an assessment interview markedly different expectations of older people and this may lead to differing lines of questioning and differing interpretations of information which is gathered during an assessment interview. Such differences could colour the overall assessment of an older person and perhaps lead to false conclusions about the older persons need for help and the type of assistance which might be offered and accepted.

2. WHAT ARE THE ELEMENTS HEALTH PROFESSIONALS WISH TO INCLUDE IN THE HEALTH ASSESSMENT OF AN OLDER PERSON AT HOME?

The prompt list (page 114) shows the assessment categories suggested by the study sample. The categories cover an extremely wide range and include items which traditionally might be considered outside the scope of health assessments. For example, finance and leisure activities were mentioned by health workers as well as those participants from the social services. The general emphasis in the responses was on the assessment of functional capabilities rather than detection of diseases. The views of the participants therefore support the move from screening to case finding which was noted in the review of the literature in part I.

3. DO HEALTH PROFESSIONALS HAVE A STRUCTURE FOR THEIR ASSESSMENT OF OLDER PEOPLE AT HOME?

Although collectively the groups shared a common view of the scope and content of assessments, it was the exceptional individual who appeared to have a clear concept and logical approach to the assessment of older people. The three participants who had made a special study of health assessments of older people naturally provided much more comprehensive responses than the rest and they had a logical sequential approach in their replies with detailed and practical comments about physical capabilities, mental status, attitudes to health and the availability of social support. The rest of the study sample made comments in a haphazard fashion with no plan or framework apparent in the replies.

4. CAN A FRAMEWORK OF ASSESSMENT BE DERIVED WHICH IS COMMON BOTH TO THE DIFFERENT PROFESSIONAL GROUPS AND TO THE GROUPS OF OLDER PEOPLE?

In spite of lack of a clear framework of assessment in the responses of most individuals, there was a remarkable consensus in the categories of assessment identified by the professional groups and the two groups of older people. This is an important and encouraging finding.

Differences in emphasis between the professional groups were apparent

and in all professional groups there were few responses suggesting the following areas of assessment: feet, continence, toileting, hearing, security and telephone, medication, memory and orientation, bereavement, sleep, teeth and dentures. Apart from the small group of social work students, few other participants recommended assessing of the older person's own views and feelings.

The studies in Part II provide evidence to suggest that collectively older people, health and social service personnel do share the same concept about the content of health assessments. This should be beneficial. Health and social service personnel can be reasonably confident that their elderly clients will not be surprised or offended by the content of a health assessment interview. Similarly, at least the basis for an effective team approach to anticipatory care of the elderly exists if the different professional groups share the same ideas about scope and content of assessment.

5. DO THE CONCEPTS OF STUDENTS ABOUT THE SCOPE AND CONTENT OF HEALTH ASSESSMENTS CHANGE DURING TRAINING?

The responses of the district nurse students at the end of the course had changed from those given at the beginning of their training. They had learned a theoretical framework of categorising health needs and the majority of the students at the end of the course simply listed the headings of this framework without applying it to the particular circumstances of the older woman shown on the video recording. It is not possible to know the effect of their course on their actual assessment of older people but their responses did <u>not</u> suggest that they had become more sensitive to the individual needs of older people. Their responses to the first two questions in the first video study showed that at the end of their course they had not improved in their observation of problems and did not identify any more actual or potential problems when compared with their responses at the beginning of the course.

Health visitor students also participated in the study at the beginning

and at the end of their course. They also failed to show any consistent improvement in their responses to the questions as measured by the number of problems observed and the number of assessment categories they wished to include in an interview.

The results of the health visitor students and district nurse students do not indicate that their education and training had a positive impact on their ability to assess the health needs of older people at home. This is not surprising as these groups did not receive specific guidance on this aspect of their work. The evidence from the response of the district nurse students indicated that they had adopted a theoretical approach to the assessment of health needs during their course and this had become a barrier to detailed consideration of an individual's health needs.

Their responses are in contrast to those of the group of physiotherapy students who had been instructed in the detailed assessment of mobility problems. In spite of having little practical experience of assessing older people at home, this group were able to build on their expertise in this area and so extend their assessment to many other areas of function.

6. ARE HEALTH PROFESSIONALS POSITIVE IN THEIR ATTITUDES TOWARDS VISITING OLDER POEPLE? DOES TRAINING INFLUENCE ATTITUDES?

The views and feelings of the different professional groups towards working with older people were ascertained by means of open-ended questions and by the use of semantic differential technique. The two methods were designed to be complementary and both stimulated generally positive responses from the participants about this aspect of their work. This is encouraging but needs to be interpreted with caution. It is possible that in a test situation participants are reluctant to reveal negative feelings about a normal part of their work. The pattern of responses is therefore perhaps more illuminating than this general finding.

In the semantic differential study, the adjective pairs selected to measure evaluative feelings of warmth and interest generated a more

positive response than did the adjective pairs selected to relate to the effectiveness of visits to the elderly. Experienced professionals gave less positive responses than did their corresponding students.

Although generally positive, responses to the open-sided questions indicated feelings ranging from enjoyment to anger about working with older people. Although the majority in each professional group were positive about this aspect of their work, many qualified their initial favourable comment with reservations. The health visitor group showed the widest range of response from enthusiastically positive to the frankly hostile. Again it was striking that students were, on the whole, more positive than their experienced colleagues and that towards the end of training ambivalence about this aspect of their work in the students increased. Health visitor students had developed reservations at the end of their training about; the outcome of their work with the elderly, the functioning of the primary health care team, and the level of provision of resources and services for older people. This pattern of ambivalent feelings closely mirrored that of the fieldwork teachers. Both in their shift in attitude and in the decline in the number of visits the students expected to make to older people, the importance of the fieldwork teachers as a role model for health visitor students is apparent.

Some individuals had been greatly influenced in their views by a previous experience in dealing with older people. The influences were both positive and negative and related to personal and professional experiences. The strength of the comments demonstrated the crucial importance, at least for some people, of their early experience of working with older people. The first professional contact many students have with older people is in a general medical or geriatric medical ward. The severely disabled and mentally impaired older people who are in such wards may give students a misleading and pessimistic view of old age and of their own potential job satisfaction in working with older people.

The evidence presented here and in previous published work suggests that

health workers become less positive in their feelings towards working with older people as they progress through training. The evidence is not strong and different interpretations of the evidence are possible. People may become generally less positive in their expression of feelings as they get older and the differences in mean scores between experienced groups and student groups may simply reflect this ageing process, even in the young! However, from the evidence of the changes in expressed feelings by the group of health visitor students, it can be said that their views became similar to those of their fieldwork teachers and that not all the changes can be interpreted as beneficial.

A few health visitor students made comments which challenged the approach of their fieldwork teachers and some general practitioner trainees also challenged the approaches to health care of the elderly which they experienced in their training practices, indicating that not all students adopt the values and work practices of their teachers.

In summary, the two methods of ascertaining the feelings of the participants produced broadly similar responses:

1. Health workers have generally positive feelings towards working with older people.
2. Expressed feelings are less positive in the more experienced groups.
3. Ambivalent feelings appear to be linked to doubts about the effectiveness of intervention.

7. DOES THE VIEW OF THE ROLE OF ONE PROFESSIONAL GROUP IN ITS WORK WITH OLDER PEOPLE AS PERCEIVED BY OTHER PROFESSIONAL GROUPS ACCORD WITH THE PROFESSIONS' OWN PERCEPTION OF THEIR ROLE?

In the video studies, the question which asked which health professional should visit the elderly woman and why, prompted responses which suggest important discrepancies in the perception of roles. Professional groups appeared to have a much wider view of their own role than that ascribed to them by others. In the video study, the reasons put forward for involving other professions in visiting the elderly women produced

carricatures of roles. For example, general practitioners were expected to visit the elderly woman to sort out her medications and district nurses were expected to visit in order to help her bath. In contrast to these views, both of these groups said of themselves that they wished to visit the elderly woman to assess her needs and monitor her progress. Few general practitioners mentioned medications and even fewer district nurses mentioned bathing as reasons for their own visits.

SUMMARY OF FINDINGS

* Differences in the identification of health needs of an older person at home were found to reflect both different professional perspectives and different individual perceptions.

* The elements of health assessment of older people put forward by the different groups of health professionals and by the two groups of older people cover an extremely wide range of categories and include items, such as the assessment of attitudes, which are difficult to measure. Overall emphasis was given to the assessment of the functional capabilities of the older person being visited.

* Although collectively the groups involved in the study shared a common view of the scope and content of assessments, it was the exceptional individual who appeared to have a clear concept and logical approach to the assessment of health needs of older people at home.

* A clear consensus in responses from the different groups made it possible to construct a framework of assessment in the form of a prompt list.

* The responses of district nurse and health visitor students at the beginning and end of their training did not indicate that their educational experience resulted in positive changes in their skills in the assessment of older people nor in their attitudes towards working with the elderly.

* All the professional groups expressed positive feelings towards working with older people but many participants in all groups had reservations about the effectiveness of their interventions. The groups of experienced health professionals were less positive in their comments than the student groups.

* There was marked overlap apparent between the roles of different health professions in their work with older people. The perception of another profession's potential contribution to the care of an elderly person was narrow compared with that professions own perception of its role.

IMPLICATIONS OF THE RESULTS

The studies reported in Part I demonstrate the continuing reservoir of unmet health needs in older people in the community. Consumer groups advocate regular health checks for older people (Age Concern 1987) and the changes for primary health care envisaged in the Government's White Paper (DHSS 1987) include a proposal for comprehensive regular review of older people. In spite of these mounting pressures, schemes of anticipatory care for older people by health professionals remain exceptional (Taylor and Buckley 1987).

WHY HAS THE SYSTEMATIC SURVEILLANCE OF HEALTH NEEDS BY OLDER PEOPLE NOT BEEN IMPLEMENTED?

There are many possible reasons for the lack of development of programmes of anticipatory care for the elderly in general practice. I shall try to focus on the findings in Part II of the thesis which are relevant to this question.

LACK OF FRAMEWORK

The video studies in Part II showed that individual health workers did not have a clear framework for their assessment of older people but that collectively they put forward a consensus view which gave assessment an extremely wide scope. This broad concept of assessment may explain why the methods used in published surveys which have demonstrated unmet health needs in the elderly have not been adopted by health professions for their routine use in their clinical work.

WIDE SCOPE OF ASSESSMENT

It would be possible but expensive and tedious for all the assessment categories on the prompt list to be assessed for all older people. The different categories differ in importance and in complexity. The initial assessment of mobility is simple and clear cut relative to the difficulty in assessing mental status and attitudes. Assessing functional ability in some areas will be necessary only if the major categories of mobility and/or mental status are impaired. For example, it might be superfluous to assess the ability of an elderly person to shop if no impairment in

mobility or mental status was detected. Alternatively, if severe impairment of these categories was found, important subsequent information concerning the ability of the carer to cope with, for example, shopping should be sought. Thus a flexible approach to assessment seems sensible with focussed and detailed attention given to areas of possible impairment only if an initial broadsweep of functional abilities has revealed potential problems. This two stage approach to anticipatory care is discussed later in the section 'ROUTES TO ASSESSMENT' on page 137.

Appreciating that health assessments of older people at home can cover a very wide area and that selected categories may need to be explored in depth leads, in my view, to a rejection of the rigid protocols which have been used in surveys of health need of populations as appropriate methods of assessing the needs of individual elderly people on a continuing basis. This argument is developed further in the next two sections. This conclusion appears untidy and may create problems for health service managers who wish to gather information in a uniform manner in their attempts to allocate resources in a fair way. However, the planning of health services should be on a deeper understanding of health needs than can be provided by superficial numerical data.

HEALTH ASSESSMENT NOT PROBLEM IDENTIFICATION

In the questions put to the participants in the studies in Part II, either the term 'health assessment' was used explicity or a scene was portrayed where problems and disabilities for the older person portrayed were already apparent. I was aware at the time of planning the studies that health professionals were not making use of standard protocols and schedules of assessment but I was not fully aware of the importance of the distinction between problem identification and problem assessment. By placing the focus of attention in the studies on health assessment, I was taking a step away from population screening into the clinical area of forming judgements about the importance of problems and disabilities and making decisions about the appropriate action to take.

Appreciating the distinction between the identification and the assessment of disabilities is crucial in determining the way in which the anticipatory health care of older people in the community might develop, I examine the differences between the two activities in the next section.

HEALTH ASSESSMENTS NOT POPULATION SURVEYS

The studies referred to in Part I which detected unmet health needs in the elderly used survey techniques. This was appropriate. The studies aimed to demonstrate levels of disability in selected populations. The use of protocols with defined categories enabled the collected data to be analysed. Even so, most of the studies can be criticised for failing to validate the methods and for failing to test for inter-observer variation. It is noteworthy that in the United States of America, the Duke University schedule of case finding (Duke 1978) which has been subjected to tests of validity and reliability uses lay interviewers who are not expected to form judgements about the significance of the problems they identify nor to be responsible for providing care for the older people who are being interviewed.

There are advantages in separating problem identification from health assessment. Many participants in all professions in the video studies moved immediately from the identification of a problem to suggesting a solution.

Problem solving is a natural and appropriate pattern of behaviour in primary health care which still mainly consists of responding to patient initiated contacts. If attempting to anticipate health problems, such behaviour may focus attention prematurely on the most obvious health problems, less obvious and less easily soluble chronic problems such as urinary incontinence may tend to be overlooked in the haste to instigate treatment for medical problems such as congestive cardiac failure.

Recommendations to implement programmes of anticipatory care in the

elderly such as that of Age Concern (1986), appear to assume that problems identified by simple questionnaires would be competently dealt with by referral to the primary health care team. There are two errors in this assumption. As the results of the studies in Part II show, there is no guarantee the individual professional concerned will be competent or necessarily interested in following up such a referral. There is also the possibility that the health worker may have a different perception of the health needs of the older person concerned than those identified from the answers to the questionnaires or from the disabilities identified at an initial case finding interview.

PROBLEMS IN TRAINING AND TEAM WORK

The broad scope of health assessment of older people and consequent need for flexibility in approach have major implications for the training and education of the health workers who are expected to carry out this task. Professionals who interview older people need to be skilled in identifying all the areas of possible impairment and should then be able to focus on these areas in such a way as to define and describe the problems in a sensitive and accurate fashion. Thus a patient with a problem of mobility should have that problem defined in such a way that the effect on function and on the patient's quality of life can be determined. This assessment should lead to a clear plan of action which can be agreed with the patient. Similarly, it should be possible for interviewers to describe and define impaired mental functioning in such a way that appropriate referral or intervention can be made.

The present training of health professionals who ultimately work together in primary care does not guarantee that at the end of training individuals will have experience or be tested in their ability to assess the health needs of older people at home. Health visitors are expected by other professions to take a leading role in the anticipatory care of elderly people but their training is largely concerned with the welfare of

pre-school children. Health visitor students are expected to visit at least one elderly person during their fieldwork training but the evidence presented in Part II suggests that this experience and the theoretical training received by district nurse students does not necessarily lead to improvements in the skills of the students in assessing the health needs of older people.

An additional problem is that the training of each health profession takes place in isolation. The evidence presented in Part II demonstrates that there is a major overlap in the roles of different members of the primary health care team in relation to the care of older people in the community and each profession had a wider view of its own role than that ascribed to it by others. This discrepancy in the perception of roles is possibly an impediment to effective team functioning. It may result in inappropriate referrals and thereby cause frustration and annoyance. Because of the large number of disabled elderly people and the types of health problems they experience, the assessment and management of their health needs requires effective teamwork. At present, preparing health professionals for working in multidisciplinary teams does not receive a high priority in education.

WAYS FORWARD

LESSONS FROM OTHER DISCIPLINES

Experience in interview techniques in other disciplines may help in understanding what is required in assessing the health needs of older people in the community. Psychiatry and general practice both have to deal with human problems which are difficult to quantify. In order to compare the results of different treatments for psychiatric disorders, it was found necessary to create tests and scales which could reliably describe and categorise patients. For example, the Hamilton Rating Scale (Hamilton 1967) has been used extensively, both as a tool for the diagnosis of depression and also as a scale against which changes in symptoms as a result of treatment can be measured. This does not mean that the Hamilton Rating Scale is used routinely in clinical practice in the diagnosis of depression. Experienced psychiatrists are aware of the components of the rating scale and are also aware of the complex patterns of symptoms which can occur in a depressed patient. Clinicians may use the rating scale if they are uncertain about the diagnosis of depression and the results of the tests then become one element in a whole range of features which may support or refute a diagnosis of depression.

Similarly, in the health assessment of older people, it may be very clear from observation of the older persons' behaviour and their answers to questions that there are severe memory problems. Further questions should then be asked to establish whether the older person has dementia. In cases where there is doubt, it might be worthwhile to employ standard validated tests for memory, concentration and orientation.

A further useful approach in psychiatry has been the development of the modified standard interview (Rutter & Cox 1981). In this technique the areas of interest which should be covered during an interview are specified in advance and the interviewer is aware of this 'agenda'. This technique has been particularly useful in ensuring that all the relevant aspects of family functioning are covered during interviews

with couples who have marital problems. In the context of health assessments of older people at home, the prompt list could serve as an agenda and knowledge of this agenda should help health professionals to ensure that they do cover all the important aspects of patients functioning during an assessment interview. In contrast to the Hamilton Rating Scale, the modified structured interview lends itself to being incorporated into normal clinical practice. It might be argued that lack of standardization in approach may lead to a reduction in the reliability of the assessment compared with a totally structured approach. The work by Rutter has shown that good levels of inter-observer reliability can be achieved.

In a different context, a study entitled 'Interview or interrogation' (Linfors & Neelon 1981) compared different interview methods in a medical outpatient clinic. This showed that, although unstructured interviews produced numerically less items of information about patients than did a structured 'interrogation' using a standard questionnaire, the quality of the information gained on interview was considered to be superior to that gained by the rigidly structured approach.

CLINICAL PRACTICE

The health needs of older people are varied and unpredictable. Areas of primary care which have been found suitable for the use of proformas are those which have a limited number of variables to record and monitor. For example, in ante-natal care and in the management of chronic diseases such as diabetes and epilepsy. In the developmental surveillance of pre-school children, recent personal experience in West Lothian has shown that an attempt to extend the number of variables recorded in a standard way, has adversely affected a surveillance programme with the participating health visitors and general practitioners resistant to filling in the elaborate proformas. Bain (1977) had previously shown that even relatively simple protocols for development surveillance were not carried out or recorded in a consistent fashion.

The responses of the participants in Part II show that they place health assessment firmly in the area of clinical practice. Thus this activity has all the strengths and weaknesses of other clinical methods. It is flexible and can adapt to the particular circumstances of the patient concerned. Questions can be modified and answers interpreted in the appropriate context. The weakness of the clinical approach is that unless special monitoring of performance is undertaken, it relies on the individual skill of the professional concerned. Some studies have considered themselves to be comparing different systems of health care when, in reality, they may have simply been comparing the clinical skills of different individuals (Vetter et al 1984).

The development of clinical skills forms the core of medical education. Recognising that health assessment of older people lies within the sphere of clinical methods should enable it to be taught and competence in it examined. The new Diploma in Geriatric Medicine of the Royal College of Physicians of London includes a clinical examination. Other organisations responsible for setting standards should be examining the competence of health professionals in a similar way.

ROUTES TO ASSESSMENT

The health assessments as envisaged by the participants in the studies in Part II are extensive and time consuming. Such health assessments would be superfluous for many older people living at home and a two-step strategy for anticipatory care of older people is a logical approach which can make maximum use of scarce resources. Barber and colleagues (1980) pioneered this approach when they sent a postal questionnaire to older people in Glasgow. This questionnaire, which asked nine simple questions, accurately identified patients who required further assessment. A disadvantage of the method was that it identified a very high proportion of the total population who did require subsequent visits and assessment by a health visitor. Modifications of the postal questionnaire are being evaluated in other parts of the country and initial results suggest that in other communities a smaller proportion of elderly people may require to be fully assessed. (Cameron & Porter in Taylor & Buckley 1987).

Other methods of identifying elderly patients who may be at risk and therefore might benefit from a full health assessment have been described (Taylor & Buckley 1987). Experimental schemes in the south of England use lay volunteers to interview all the people over the age of 75 years in selected communities. Those who are detected as having problems then receive a visit from the health visitor or general practitioner. Freer (1987) has suggested that general practitioners should make more effective use of the present high level of contact they have with their older patients. Asking Barber's screening questions within a consultation might identify patients who should make further longer appointments or who should be visited at home by one of the primary health care team members.

Berrey (in Taylor & Buckley 1987) suggested making use of the existing data held by primary health care teams about elderly patients in order to identify in a dynamic way the patients who are most likely to be in need of health assessments and he is evaluating the use of a computer in collating and processing this information.

Carrying out health assessments on the total population of elderly patients in a general practice has been demonstrated to be feasible provided that there is active co-operation and enthusiasm for the work by different team members. However, anticipatory care of older people is likely to be implemented on a wide scale only if the numbers who require to be assessed are reduced to a small number each week.

Taylor & Ford (1983) have looked at the effectiveness of using demographic and relatively static criteria to identify older people who are most likely to benefit from health assessment. Although some features were associated with higher levels of need than the average, for example those divorced/ separated and those who have recently moved house, these general criteria were not found to be helpful in identifying a small group of older people who needed to be assessed. The study did demonstrate that living alone was <u>not</u> a good indicator of an elderly person having unmet health and social needs.

The use of information about elderly people on an individual and dynamic basis as suggested by Berrey may be more successful in reducing to a manageable size the number of older people who require to be visited.

The wide variation in responses of individuals in different health professions in the studies in Part II, differences in characteristics of populations of older people in each district, and differences in available resources combine to indicate that the precise methods of providing anticipatory care for older people will vary from locality to locality.

RECOMMENDATIONS

RESEARCH RECOMMENDATIONS

The next phase of research in the area of anticipatory health care of older people in the community should be educational and operational. Previous studies have defined the extent of unmet health needs in the elderly in the community. This thesis has clarified the scope and content of health assessment and has revealed that existing educational approaches do not produce a clear improvement in the skills of district nurses and health visitors in the health assessment of older people at home. It has also been shown that in all the health professions studied, training and experience is not associated with attitudes towards working with older people becoming more positive.

We know in broad terms why anticipatory care of the elderly needs to be undertaken. We know also the areas of assessment which need to be covered. A number of different methods of implementing anticipatory care have been described (Taylor & Buckley 1987). Thus, there are various possibilities of how anticipatory care could be implemented. There is no shortage of ideas, but the different schemes are being tried out in an ad hoc and unco-ordinated fashion. We need to learn not only from the outcomes of different types of intervention but also from the problems encountered in setting up programmes of preventive care. The extent of involvement of different health professions, their feelings about this aspect of their work, and the difficulties encountered in sustaining the programme, are all important aspects which need to be evaluated. For example, it should be possible to compare different two-stage methods of case finding; one using a postal questionnaire and the other using lay interviewers.

It is clear that there has been a secular change in approach to preventive care in the elderly on the part of health professionals. There has been a move away from a desire to look for presymptomatic disease to a consensus in favour of functional assessment. Other than in crude quantitative terms (OPCS 1974 & 1986) it is not known whether there has been a secular change in the use of health services

by older people. The National Health Service is 40 years old in 1988 and people who are 60 years of age this year have spent the whole of their adult life knowing that they have health care which is free at the point of use. It is not known whether this experience or other factors will influence their use of health services as they grow older. It has been demonstrated in the past that patient initiated contact with the health services does not reveal many health problems. It is important to continue to carry out surveys of the health needs of older people at home in order to know if older people still have a large number of unmet health needs which are unknown to the primary health care team.

MANAGERIAL RECOMMENDATIONS

The health care problems of the elderly can seem to be so large that they paralyse action. One profession in isolation could not cope in implementing a system of anticipatory care for older people and the co-ordinated efforts of different health professions are required. Multi-disciplinary teams are difficult to create and maintain, even in a hospital setting, but the creation of primary health care teams is seriously hampered in the United Kingdom by the major differences which exist in the management structure of the different professions. The independent contractor status of general practitioners contrasts starkly with the line management organisation of community nursing services. The Cumberlege Report (DHSS 1986) addressed this problem from a nursing perspective and the proposals encountered opposition from general practitioners who saw them as weakening their position as the effective managers of primary health services in the community.

The comments reported in Part II illustrate the difficulties individuals encounter in establishing effective teamwork even when, at a personal level, relationships within the primary care team are good. In addition to these major problems in the managerial structure of primary health care in the United Kingdom, the responses in Part II demonstrated that there is a wide variation in enthusiasm within each health profession for providing anticipatory care for older people in the community and I have referred earlier to the multiplicity of different types of schemes of assessing the health needs of older people (Taylor & Buckley 1987). Uniform systems of surveillance of the elderly are therefore not likely to be agreed or implemented. Nevertheless, the studies in Part II do demonstrate that most health professionals are positive in their wish to work with older people in the community and the appropriate role of managers should be to support local initiatives where they occur and stimulate them where they do not.

Additional resources are necessary to implement a preventive service (Tulloch & More 1975, Hendriksen et al 1984) but much could be achieved if health authorities had a clear policy which encouraged

anticipatory care in the elderly. At every level in the health service, opportunities should be taken to highlight the importance of anticipatory care in the elderly and so give this work a high priority in the minds of individual health workers.

For planning purposes, health authorities have legitimate needs for information about the elderly but routine data collection for use by others was found in the exploratory studies to be burdensome by health visitors who questioned the value of this aspect of their work. A more constructive approach would be to collect information which is of direct benefit to the individuals concerned; the patient and members of the primary care team. This information should be helpful not only in providing health care, but also in defining and solving local health problems. This information could then form part of the annual reports of primary health care teams which are recommended in the government's White Paper (DHSS 1987).

Sharing information about individual patients and collaborating in the writing of annual reports may prove to be the most useful way of developing effective teamwork in primary care. By avoiding unnecessary duplication, teamwork could bring the workload of anticipatory care for older people down to manageable levels.

These managerial recommendations may seem vague but this is inevitable when the structure of primary health care makes it impossible for central directives to be enforced.

EDUCATIONAL RECOMMENDATIONS

Recommendations for changes in the education of health professionals are based on a number of different findings in the studies described in Part II. It was clear that individual health workers did not have a clear framework for their assessment of the health needs of older people at home. Skills in assessment did not appear to improve during training. Similarly, educational experience was not associated with attitudes towards visiting elderly people at home becoming more positive. Indeed, the comments made by some participants suggested that early experience in working with older people could have a powerful negative effect on their feelings towards working with older people. Exposure in a hospital setting to the severely ill elderly people who have multiple disabilities is unlikely to be the best introduction to learning about the preventive care of older people in the community.

Careful consideration needs to be given to the way in which young and inexperienced health workers are introduced to caring for older people. The need for specific training about health assessment of older people should not obscure the importance of providing the appropriate context for such training.

At present it is still possible for general practitioners, health visitors and district nurses to become fully qualified without being taught or becoming skilled in the assessment of the health needs of older people at home. There is a need for the education to be based on practical skills. Theoretical models and concepts about ageing may be of interest but are no substitute for developing skills in interviewing older people and helping them with their health problems.

The responses of the participants of the studies described in Part II show that all professional groups wished to be involved in the health assessment of older people and demonstrate that there is considerable overlap in the roles of different members of the primary health care team. The studies show that different professions perceive problems in different ways. If older people are to be offered the widest possible choice of

In addition to these multi-disciplinary groups, there is also a need for peer groups of professionals from several teams to meet together. In these meetings colleagues can share ideas, describe initiatives and discuss the problems they are encountering.

From the fieldwork, it was apparent that there is a need to develop better methods of sharing information between the different members of the primary care team. The sharing of routine information might prevent duplication of effort and so reduce the workload in this demanding area of care.

In specific terms, the techniques involved in the studies were found to be useful educational tools. The prompt list created by the responses of the participants in this study can be considered to be a framework for teaching. The use of short excerpts of video-recordings of real interviews was found to be a powerful educational method which evoked strong reactions from students and it enabled learning to be focussed and structured whilst continuing to be based in reality.

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APPENDIX I

VIDEO-RECORDED INTERVIEWS - TOPICS COVERED

Mrs C - 51 minutes

1. Attitudes towards carers
2. Mobility
3. Death of husband and other relatives
4. Social contact and support
5. Relatives and neighbours
6. Memory
7. Household tasks: cooking
8. Appetite and diet
9. Bowel function
10. Self-medication
11. Digestion
12. Mobility
13. Foot care
14. Examining feet
15. Ankle oedema and varicose veins
16. Hazards/slippers
17. Deep venous thrombosis
18. History of falls
19. Getting help in an emergency
20. Friends
21. Loneliness
22. Interests
23. Vision
24. Hearing
25. Teeth
26. Bladder function
27. Medicine taking

Mrs S - 33 minutes

1. Symptoms - pain
2. Household tasks
3. Family relationships: problems associated with moving home 'to be near the family'
4. GP's attitude to the move
5. Family strife
6. Feelings about the future
7. Attitude to death
8. Medicine taking
9. Depression
10. Coping with loneliness
11. Interests/attitudes
12. Vision
13. Hearing
14. Feelings about using hearing aid
15. Bladder control
16. Bowel function
17. Medicine taking
18. Memory
19. Husband's last illness and death
20. Feelings about husband's death
21. Feelings about old age

Mrs. L - 37 minutes

1. Problems since discharge from hospital
   - cooking
   - using Zimmer
2. Occupational therapist's assessment
3. Home help
   - household tasks
4. Appetite
   - diet
5. Weight loss
6. Sleep
7. Balance
   - history of fall
8. Post-op complications
   - breathlessness
9. Difficulties getting outdoors
   - using lift
   - Zimmer
   - attitude towards getting out
10. Medicine taking
11. Smoking
12. Mobility
    - pain
    - feet
    - feelings about information giving in hospital
13. Difficulties dressing
    - District nurse
14. Feelings about the future
15. Friends/visitors
    - feelings about
16. Loneliness
17. Interests
18. Vision
19. Washing stairs and windows
20. Hearing
21. Memory
22. Teeth
23. Toileting problems
    - using commode after discharge from hospital
24. Carrying things in house
25. Getting help
26. Toilet aids
27. Dressing
28. Buying clothes
29. Bladder control
30. Bowel function
31. Perception of health
32. Plans for the future
33. Outdoor interests
34. Planning for discharge from hospital
35. Pain
36. Other medicines (over-the-counter)

Mrs W - 49 minutes

1. Views of her own health
2. Self care
   - bath
   - aids
3. Balance
4. Dizziness
   - rising from chairs
5. Demonstrates walking
   - use of stick
6. Stairs
   - angina
7. Shopping
8. Home help
9. Household tasks
10. Family support
11. Interests
12. Holidays
13. Shopping with family
14. Chiropodist
    - examining feet
15. Self care
    - washing
    - dressing
16. Son
17. Grandchildren
18. Visitors
19. Interests
20. Vision
21. Neighbours
22. Hearing
    - looking in ears
    - views about hearing aids
23. Weight loss
24. Appetite and diet
25. Cooking
26. Medicine taking
27. Bladder
    - stress incontinence
28. Sleeping pills
29. Church contacts
30. Feelings about
    - old age
    - old people
31. Memory and orientation
32. Husband's death
33. Bills
34. Shopping for clothes
35. Teeth
    - looking in mouth
36. Digestion
37. Over-the-counter medication
38. Bowel function and control
39. Anginal pain
40. Dizziness/balance
41. Bending/environmental control
42. Hazards
    - mirror over fire
43. Hazard
    - getting to follow-up clinic
44. 'Charity'
    - attitudes to

Mrs F - 40 minutes

1. Views about health and self care
2. Sleep
3. Medication
4. Household tasks
5. Mobility
6. Balance
7. Walking aids
8. Falls
9. Vision
   - glasses
10. Access to toilet
11. Fears
   - 'young thugs'
12. Personal hygiene
13. Bath aids
14. Dressing
15. Washing clothes
16. Views about getting out of house
17. Finance
18. Feet
   - chiropody
   - examining feet
19. Mood
20. Depression
21. Worries about family
22. Feelings about future
23. Memory
24. Appetite
25. Diet
26. Teeth
27. Bowel function
28. Bladder control
29. Hearing
   - problems with hearing aid

APPENDIX II

VIDEO STUDIES

Excerpt 1 - Transcript of the interview with Mrs C

PR Your health visitor explained to you that Dr. Buckley and I were interested in some of the problems that older people have with their health?

Mrs C Now, you're quite right. I don't see too well.

PR I'm interested in just how you manage from day to day with some of the ordinary everyday things.

Mrs C I'm afraid I don't manage very far. I just listen to my nieces but I don't pay much attention to them, I just leave them to it.

PR What things do you find difficult?

Mrs C Well, I can't kneel down and if I bend over I lose my balance. My balance is not good, and of course this doesnae help it - this collapsed fracture.

PR Yes, you were telling me you had a fracture in ... your right leg, was it?

Mrs C This here, and that's ten year ago.

PR Ten years?

Mrs C I fell in S Road, and they took me into the infirmary, I remember. My husband had just ... he'd only six months to live. He'd retired ten years - like, some years before that, when he was put off his work because of rheumatoid arthritis. So when I was carried into the infirmary that day, a doctor came and said who he was, like, you see - and he said: "You'll be here for five days" (actually it was a week). He said, "And then you'll go down to E". I said, "I can't go down to E. I've left my husband at home, crippled with rheumatoid arthritis". He says, "What're you talking about? Nobody could have more of it than what you've got yourself, you're full of it." I thought, "By jove, you're a right Cheerful Charlie, right enough! You talk about sinking ... ! Well, I had no choice in the matter. But they moved me from there at the end of the week".

PR And your husband was here at home at that time?

Mrs C He was home here, but my nieces came in each day to him. But he could get about and could get down the stairs by that time. First he couldn't. But he could get about and get down the stair by that time and that sort of thing.

PR How long have your been on your own now in the house then?

Mrs C Since 1973. I had six deaths in my family.

PR Oh, my goodness!

Mrs C My elder sister went just in February. My husband died in May. Another niece's husband dropped dead and he wasn't sixty. Dropped dead leaving his work one night. And then my niece that used to come and take me out in her car, her father had been lying in the nursing home for months with a stroke and she used to go every day and take her mother in to see him. She went this day, she couldn't get into the house.

APPENDIX III

VIDEO STUDIES

Excerpt 1 - Scope and content of assessment - 46 categories

Question 1 & 2 Observations and Problems	Question 3 Assessment Items
MOBILITY *	
Mobility/ walking poor, restricted Getting around inside, outside Ability to get out Being housebound	Can/does she get out Can she visit essential parts of the house* How far can she walk outside * Is she able to climb stairs * Can she use transport * Upper/Lower limb function Muscle power Dexterity/manipulation Grip strength
BALANCE *	
Balance poor Gait unsteady Dizzy on bending Unable to kneel/bend to pick up things	How steady is she Gait *
FALLS *	
History of/tendency to falls Risk or danger of falling/ tripping Fear of falling Fall and be unable to rise Fall and be undiscovered	History of falls Can she get up off floor
TRANSFERRING *	
Difficulty getting out of chair	Can she get - in/out chair * - in/out bath - in/out bed * - on/off toilet *
FEET *	
Might need chiropody Foot problems possible	Condition of feet Need for chiropody * Does chiropodist visit Foot wear Does she think she has foot problems

Observations and Problems	Assessment Items
AIDS *	
Walks with stick Stick inadequate Stick not used properly Zimmer would have been better Holds on to furniture	Need for aids - for mobility e.g. zimmer for bath, toilet,* kitcen* e.g. rails, raised toilet seat, bath mat/bath seat commode Are aids already available Are existing aids used, used correctly, suitable liked
SELF CARE *	
Appears to manage Possible self neglect Personal hygiene Bathing Hair washing	Can she wash/bath herself*
TOILETING *	
Getting to toilet in time	Can she get to toilet in time Does she need to get up at night
DRESSING *	
Looks cleanly dressed Looks unkempt Well dressed Neat and tidy	State of repair/cleanliness of clothes Is help needed to dress
LAUNDRY *	
Washing clothes Heavy washing	Who does washing, ironing, mending What facilities in house Is help needed
CONTINENCE *	
	Bladder and bowel control* Need for incontinence aids Need for laundry service
MENTAL STATUS *	
Mentally alert Articulate, coherent Communicates well	

Observations and Problems	Assessment Items
MEMORY *	
Recalls past events	Short and long term memory
ORIENTATION *	
Fully orientated Not confused	
MOOD *	
Cheerful, sense of humour, withdrawn, anxious realistic, depressed, bored, enjoys talking, apathy, possible loss self-esteem, stubborn, dogmatic, proud	Is she anxious, depressed,* worried
LONELINESS *	
	Is she lonely
BEREAVEMENT *	
Grief* Loss of many relatives	
SLEEP *	
	Sleep pattern* Need for drugs
ATTITUDES *	
Friendly, welcoming Forthcoming personality Attitude to niece Content with niece's help Reluctant/unwilling to accept help Doesn't listen to niece Unwilling to change Independent, determined Lacks confidence Aware of disabilities	How does she feel about: Living alone Her present house* Moving house The way she is coping at present The future Increasing frailty Going out Meeting people Her need for help Accepting help* Being assessed Other activities and social outlets Her daily activities

Observations and Problems	Assessment Items
HOUSE *	
Lives upstairs	Can she climb stairs
Low, unsuitable chair	Would higher chair be better
Furniture unsuitable	Suitability of usual chairs
Room cluttered, crowded	Could furniture be better arranged*
Room uncluttered	Location, access to and adequacy of: toilet/bathroom, kitchen, bedroom
	House: type, size, layout,* ownership, how long lived there, state of repair, upkeep, level of adaptation, width of doors, damp or cold, approach to house, access to washing line, garden
HEATING *	
Warmly dressed	Type and adequacy of heating and clothes
Not enough clothes on	Heating in bedroom
Hypothermia risk	Is house warm/cold
	Is heating used
	Can she control heating
	Can she afford cost
	Risk of hypothermia
HAZARDS *	
Rugs, carpets loose	Risk of accidents
Risk of accidents	Height of steps
Could fall on fire	Polished or uneven floors
Risk of burns	Floor coverings*
Lighting fires*	Rails on stairs
Manipulating plugs	Adequacy of lighting
Using kettle and cooker	Arrangement of furniture
	Old slippers, ill-fitting shoes
	Type of and access to switches and plugs*
	Faulty wiring*
	Trailing flexes
	Use of cooker
	Fireguard
	Mirror over fire
	Use of electric blanket
	Sense of smell (gas)

Observations and Problems	Assessment Items
SECURITY *	
Answering the door	Who has key
Getting help in emergency*	Is alarm system installed
No-one to inform of accident	What does she do if she falls
Bogus workmen	
TELEPHONE *	
	Is there a telephone
	Can/does she use it
HOUSEHOLD CLEANING *	
House looks clean	Does she have/need help
House looks dishevelled	Who does housework
	Who cleans windows
NUTRITION *	
	Is there food in the larder/fridge
	What does she eat/drink each day
	How good is her appetite*
SHOPPING *	
	Does she have/need help
	Who does shopping
	Are there local vans/shops
	Access to shops
COOKING AND PREPARING FOOD *	
	Does she have/need help
	Who does cooking
	Can she make a simple meal, snack
TEETH *	
Possible difficulty chewing	Is dentist needed
SOCIAL CONTACT AND SUPPORT *	
	Social support
	Social contact and help

Observations and Problems	Assessment Items
ISOLATION	
Lives alone* Husband dead	Does she live alone
VISITING *	
	Who visits How many How often* How near Is there a daily supervisory or surveillance visit
RELATIVES *	
Niece helps and visits No close family	Who is the main carer
NEIGHBOURS, FRIENDS AND OTHERS *	
	Type of nieghbourhood and area Is it a close community
ATTITUDES OF SUPPORTERS *	
Niece advises Niece may give up Stress on niece Attitude of niece Relationship with niece and other helpers	How supportive are they How close are they What is quality of relationship Could they do more
HEALTH SERVICES *	
	Need for nursing and other help District nurse,* Health visitor* Physiotherapist Day hospital GP - can she get to GP* Is she known to geriatric services*
SOCIAL WORK SERVICES *	
	Need for home help* Occupational therapist* Social worker Meals on wheels*

Observations and Problems	Assessment Items
VOLUNTARY AND OTHER SERVICES *	
	Local clubs, day centres Lunch club Minister, church contact Red Cross library service
LEISURE *	
	How does she spend her day Outings* Pets,* radio,* T.V.,* books,* papers
FINANCE *	
	Can she afford cost of food and heating Pensions and benefits* Who pays bills, collects pension Does she understand forms Any debt
HEARING *	
Hearing good Possibly slight deafness	Can she hear doorbell,* radio, T.V. Is aid needed,* wanted, available, used and satisfactory
VISION *	
Poor sight, blind in eye Possibly unable to read, watch T.V. Could lead to accidents	When were eyes last tested Does she have/wear glasses * Does she use other aids Can she see if clothes are stained Can she read,* see T.V. Is she registered blind
MEDICATIONS *	
	What regime is prescribed* and taken Side effects* Storage Use of aperients Use of sedatives

Observations and Problems	Assessment Items
MEDICAL HISTORY *	
Previous fracture Possible further fractures Arthritis, osteo and rheumatoid Osteomalacia, osteoporosis Muscle wasting disease Heart disease Anaemia, Hypothyroid Malignancy Upper respiratory infection Arterio-sclerosis Vertigo Vertebrobasilar insufficiency	Pain, severity of arthritis stiffness, joint range of movement, exercise tolerance, breathlessness, oedema, dizziness, change in bowel habit or weight, current treatment System check - cardiovascular locomotor genito-urinary gastro-intestinal Screen - B.P. pulse blood urine
PHYSICAL EXAMINATION	
Frail, slow, infirm, limps, leg swollen, stiff, deformed joints, thin, emaciated, underweight, mal/undernourished, temporal wasting, stooped, kykphotic, hands deformed/arthritis pallor, cyanosis, looked cold, facial bruising/injury, hoarse voice, sounds chesty, breathless, in pain	
SKIN *	
	Condition of skin and pressure areas

* Selected for inclusion in the Prompt List (Figure 6a)

APPENDIX IV

QUESTIONNAIRE - SUMMARY OF INFORMATION AREAS AND KEY QUESTIONS

ALL GROUPS

date of birth
sex
general educational background
professional qualifications
previous professional and other opportunities for work with elderly people
views and feelings

> Health professionals have different views and feelings about working with older people. How do you feel about visiting the elderly at home?

experiences influencing views

> Are there any particular experiences which have influenced your views about visiting the elderly - experiences during training, at work, with relatives or friends etc?
>
> Describe briefly.

SELECTED GROUPS

Patterns of visiting

Student HVs

> At present as a student health visitor, how many households are you visiting?
>
> In how many households do you visit an elderly client?
>
> What percentage of your visits are to the elderly at home? (i.e. when the main reason for visiting the household is to see the elderly client) *
>
> When you become a health visitor what do you expect the percentage of your visits to the elderly will be? *

Student DNs

> Questions * as above

Student HVs and DNs late in training

> What do you now expect the percentage of your visits to the elderly to be when you become a health visitor/ district nurse?

All qualified HVs and DNs

In your present post, do you visit the elderly at home? YES/NO

If YES

(a) What percentage of your visits are to the elderly at home? ....%

(b) What would you like the percentage of your visits to the elderly to be? LESS/SAME/MORE

In your present post, do you have any special responsibilities related to the care of the elderly? YES/NO

If YES please specify

GP trainees

Please describe briefly your training practice policy about home visiting of the elderly.

Approximately how many home visits to elderly patients do you carry out each week?

GPs

Do you carry out regular visits to elderly patients? Please comment

Views and feelings

Student HVs and DNs late in training

At this stage in your course and practical work/ fieldwork experience, what are your views and feelings now about visiting the elderly at home?

Have your views about this part of your work changed? YES/NO

If so, in what way?

APPENDIX V

DEFENCE OF METHODS

STUDY GROUPS

In my description of the participating groups, I have indicated those which can be regarded as representative of the respective professions, at least for South-East Scotland. The experienced general practitioners, health visitors and district nurses were not representative groups. Nevertheless, the total sample in the study is large and inferences relevant to health professions in the United Kingdom can reasonably be drawn from the overall results, particularly when a high level of consensus between the diverse groups was found.

VIDEO-RECORDED INTERVIEWS

There have been many studies reported which have used video-recordings of interviews between doctors and patients in the training and assessment of consultation skills in medicine. General practice and psychiatry have been the disciplines which have made most use of this technique (Maguire P. et al 1978, Lesser A.L. 1981, Verby J.E. et al 1979). However, these studies did not use excerpts of video-recorded interviews as a scene setting standard stimulus in the way I have described in Part II. There have been studies into the clinical judgement of and behaviour of doctors who have used other forms of visual stimuli, notably Howie (1978). The aim of my study was to provide complex clinical information in a short period of time in a standard way but, unlike Howie, I wished to elicit responses from different professional groups and the questions were not focussed on the management of a single problem. The technique was a practical method of setting a realistic scene for the subsequent questions and it was also a means of ascertaining whether participants perceived the same stimulus in different ways.

The video excerpts stimulated active co-operation from all the different groups who were approached. It had the advantage of portability and speed in characterising a complicated scenario. Whether or not a 'real' interview was better than a simulated one is uncertain and similar responses might have been given to a written description.

A number of participants commented on the reality for them of the scene portrayed. However, these comments cannot hide the fact that responses were obtained in a classroom setting and no attempt was made to corroborate the responses of participants with their actual performances in assessing the health needs of older people at home. It is in favour of the method that it allowed the views of older people to be directly compared to those of health professionals. This direct comparison has not previously been described.

In Part I, I commented on the measurement of attitudes towards older people. I concluded from my search of the literature that the object under consideration when assessing attitudes requires to be as specific as possible and that the results of studies should be interpreted in the knowledge of the precise stimulus. It is reasonable to suggest that the scope and content of health assessment also needs to be judged in terms of the specific situation portrayed. An important question then arises as to whether the excerpts of interviews which were shown can be considered to be representative of older people at home. The simple answer is: No - not all older people are females who live alone and have problems with their mobility. However, almost half the elderly people over the age of 75 do live alone (Social Trends 1987) and, of these, over two thirds are female and the three women portrayed in the excerpts do represent a large group of elderly people and a group who pose particular problems of assessment and management for the health and social services.

The decision to use video excerpts was based on pragmatic and empirical grounds. Acceptance of the validity of the results rests on the face validity of the method. Appendix I provides the details of the content of the recordings and supports the view that the particular content of the excerpts presented a realistic and recognisable stimulus to the participants and that their collected responses about health assessments allow general inferences to be made about the health assessment of older people at home by different professional groups.

SEMANTIC DIFFERENTIAL

The semantic differential technique has been used to ascertain attitudes to many different things. It has been used previously to assess attitudes to older people and old age (Rosencrantz & Witts), but comparing their results with those presented in Part II is not possible because different adjective pairs were selected and different stimuli were used. In my study, I wished to describe how participants felt about visiting an older person at home because this question focusses attention on a practical activity which encapsulates the work of health professionals with older people in the community.

The validity of this method and of the results obtained rests on two assumptions. The first is that, in general, the method produces meaningful responses. Both in this study and in previous work, responses have been shown to be repeatable. Using this method, Osgood has put forward ideas about the multi-dimensional nature of attitudes. The technique has a respectable academic background and, perhaps even more important, it is used commercially in the market research of new consumer products which indicates that its predictive ability is good.

The second assumption is that the particular question asked and the adjective pairs selected are valid in that they elicit responses which represent the range of work with older people carried out by the primary care team.

QUESTIONNAIRE

The aim of the questionnaire was to give participants in the study the opportunity to express their views and feelings about visiting older people at home. The questions were open-ended. The studies described in this thesis are qualitative rather than quantitative and this is particularly true of the questionnaire. The comments made by the participants were analysed initially as expressing positive, ambivalent or negative feelings towards visiting older people at home. Of more interest, and possibly of more value than expressions of warmth or hostility towards working with older people, were the

themes which were of concern to the participants as judged by the frequency with which similar types of comment were made.

ANALYSIS

It is difficult to avoid bias in the analysis of data which is essentially qualitative. In categorising the comments of the participants, care was taken in using the respondents own words and checks were made for possible inter-observer variation in the scoring of responses to the first and second video excerpts. The highest initial misclassification rate was 5% for questions 1 and 2 after the first video excerpt and was less than 1% for the other questions following the first and second video excerpts (page 48). The responses to the video excerpts were classified according to a framework constructed from the replies of health visitor students. However, the categories were not artificially created in that they are the words used by participants. Appendix III shows the most frequently used words and demonstrates how these words have been grouped into the different categories.

The responses in the semantic differential were remarkably similar in terms of the rank order for the adjective pairs with a high and statistically significant co-efficient of concordance. This suggests that there is a consistent view held by all the professional groups towards working with older people. The minor differences between the different groups is of lesser importance.

FIELD STUDIES

The relationship between the responses in the classroom and the actual work of health professionals has been briefly examined in the field studies.

I wished to compare the framework of assessment created from the classroom studies with the actual assessment of older people but found this to be fraught with difficulties. These difficulties were anticipated

in the exploratory study when it was found that not only did health personnel wish to be flexible in their approach to assessing older people, but older people also demonstrated widely differing perceptions of their own health needs.

Therefore, the field studies did not attempt to test the use of the prompt list as a means of improving the assessment of older people at home. What the field studies did try to ascertain was whether the prompt list was regarded by health professionals as appropriate and helpful in the assessment of health needs of older people, and whether the list provided a means of identifying gaps in the knowledge of primary care teams about their elderly patients.

VIDEO STUDIES: Excerpt 3 - Semantic differential

UNIVERSITY OF EDINBURGH

NURSING RESEARCH UNIT and DEPARTMENT OF GERIATRIC MEDICINE

ASSESSMENT OF THE ELDERLY

We are interested in how health professionals feel about visiting the elderly.

You will see a short video of an elderly lady at home. Consider how you would feel when visiting her, by judging the concept 'Myself visiting this lady' on the set of scales at the foot of this page.

If you feel that the concept is very closely related to one end of the scale, place your check-mark as follows:

fair X : ___ : ___ : ___ : ___ : ___ : ___ unfair

or

fair ___ : ___ : ___ : ___ : ___ : ___ : X unfair

If you feel that the concept is quite closely related to one or other end of the scale, place your check-mark as follows:

fair ___ : X : ___ : ___ : ___ : ___ : ___ unfair

or

fair ___ : ___ : ___ : ___ : ___ : X : ___ unfair

If the concept seems only slightly related to one side as opposed to the other side, then check as follows:

fair ___ : ___ : X : ___ : ___ : ___ : ___ unfair

or

fair ___ : ___ : ___ : ___ : X : ___ : ___ unfair

If you consider the concept to be neutral on the scale, both sides of the scale equally associated with the concept, or if the scale is completely irrelevant to the concept, then place your check-mark in the middle space:

fair ___ : ___ : ___ : X : ___ : ___ : ___ unfair

Please place only one mark on each line.

Work quickly through the items, as it is your first impressions that are important.

MYSELF VISITING THIS LADY

Date _____
Code _____
Date of birth _____

I would feel . . .

uninfluential	___ : ___ : ___ : ___ : ___ : ___ : ___	influential
tense	___ : ___ : ___ : ___ : ___ : ___ : ___	relaxed
warm	___ : ___ : ___ : ___ : ___ : ___ : ___	cold
active	___ : ___ : ___ : ___ : ___ : ___ : ___	passive
pessimistic	___ : ___ : ___ : ___ : ___ : ___ : ___	optimistic
useless	___ : ___ : ___ : ___ : ___ : ___ : ___	useful
quick	___ : ___ : ___ : ___ : ___ : ___ : ___	slow
organised	___ : ___ : ___ : ___ : ___ : ___ : ___	disorganised.
interested	___ : ___ : ___ : ___ : ___ : ___ : ___	bored
vague	___ : ___ : ___ : ___ : ___ : ___ : ___	precise
eager	___ : ___ : ___ : ___ : ___ : ___ : ___	reluctant

APPENDIX VII

ORGANISATION OF RECORDINGS

The five ladies interviewed were aged between 74 and 85 years. The video-recording was carried out by staff from Queen Margaret College, Edinburgh.

Permission was sought from and granted by the subjects well in advance of the interview via their own health visitor and general practitioner. Subsequently formal written permission was granted the day before the interview and further discussion of the video-recording was carried out on the day of interview and the day after interview.

The following points emerged in obtaining consent from participants and informing them about video-recording:

> Written information about the purpose and technique of the recording was made available for the elderly person and for relatives/carers.
>
> Technical terms were fully explained.
>
> Several opportunities were provided to discuss, and to check understanding of the method and potential ways of using the video-recording. On the day after interview, one lady needed reassurance that she would not eventually 'appear on TV'.
>
> Professional help was available to the old person, as a back-up for the research team, in case health problems were found or unexpected anxieties provoked. On being shown her own video-recording, another lady became upset by her emaciated appearance. Her health visitor called promptly after the research team left.

A small payment was made for the electricity used in the making of the recordings.

The content, style and sequence of assessment areas covered in the video-recordings differed for each interview. The direction of the interview was influenced by the priorities and preferences of the elderly lady concerned, even when a structured approach was attempted. The topics covered in each interview are shown in order in Appendix I. The interviews ranged from 33 to 51 minutes in length and it was found that recording real interviews with older people at home was feasible and acceptable.

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Queen Margaret College, Edinburgh

Lothian Health Board

Lothian Regional Council Social Work Department

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